INDIANA

State Plan for Mental Health
Services
Fiscal Year 2006

Indiana Family and Social Services
Administration

Division of Mental Health and Addiction

September 1, 2005

FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

___FY 2005-2007 ___ FY 2005-2006 _X__ FY 2006

STATE NAME: __INDIANA_____

DUNS #: _196256994_____

I. AGENCY TO RECEIVE GRANT

AGENCY: _Indiana Family and Social Services Administration_____

ORGANIZATIONAL UNIT: __Division of Mental Health and Addiction_____

STREET ADDRESS: _402 W. Washington St. Room W353_____

CITY: _Indianapolis_____ STATE: Indiana_____ ZIP: _46204_____

TELEPHONE: 317-232-7866_____ FAX: __317-233-3472_____

II. **OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT**

NAME: _Cathy Boggs_____ TITLE: ___Interim Director_____

AGENCY Indiana Family and Social Services Administration_____

ORGANIZATIONAL UNIT: Division of Mental Health and Addiction_____

STREET ADDRESS: _402 W. Washington St. Room W353_____

CITY: _Indianapolis_____ STATE: Indiana_____ ZIP: _46204_____

TELEPHONE: 317-232-7845_____ FAX: __317-233-3472_____

III. STATE FISCAL YEAR

FROM: _July_____ __2005_____ TO: __June_____ ___2006_____

Month Year Month Year

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME:___Sue Lummus_____ TITLE:__Deputy Director for MH Policy and Planning

AGENCY Indiana Family and Social Services Administration_____

ORGANIZATIONAL UNIT: Division of Mental Health and Addiction_____

STREET ADDRESS: _402 W. Washington St. Room W353_____

CITY: _Indianapolis_____ STATE: Indiana_____ ZIP: _46204_____

TELEPHONE: _317-232-7824 FAX: _317-233-3472_ EMAIL: sue.lummus@fssa.in.gov__

Table of Contents

Executive Summary

The Hoosier Assurance Plan, adopted in 1994, continues to be the basis on which the Division of Mental Health and Addiction (DMHA) relates to and funds the Indiana mental health service system. It guides the management of public funds earmarked for mental health services, assuring that priority will be given to individuals in greatest need. Under this plan, DMHA acts as a purchasing agent, contracting with qualified managed care providers offering an array of individualized mental health and addiction care. The Division has statutory authority for six (6) state-operated facilities, and contracts with thirty-one (31) private not-for-profit community mental health centers.

The Indiana mental health system provides services in all ninety-two counties of the state. The Hoosier Assurance Plan eliminated the traditional geographic service areas. The result has been that consumers have choice of two or more services providers in many areas of the state. This coverage is demonstrated in the tracking of service provided in rural areas of the state that shows an individual living in rural Indiana has the same probability of being served as does someone in urban areas of the state. All providers must provide a Continuum of Care as defined in Indiana Code and by rule. This assures that all individuals served have access to a full array of services ranging from inpatient treatment to medication monitoring.

The mental health centers are operating as the gatekeeper for state hospital admissions creating a system in which the community provider continues as an active partner during a state hospitalization and is actively involved in discharge planning. Each mental health center, through bed allocation, has a limited number of state hospital beds for their use.

The Division has a ten year history of moving funds from the state operated facility budget to community based services. The Division remains committed to continuation of this dedication to community based services.

Achievements

- Continuation of state sponsored cultural competency classes.
- Continuation of efforts to promote evidence based practices.
- Submitted a Transformation grant application along with a serious examination of present operations and a focus on change.
- Worked with legislators in development of statute to allow confiscation of guns when a person is considered “dangerous”.
- Provided Wellness Recovery Action Planning (WRAP) for 232 persons; seven Self-advocacy skills seminars were held with 106 persons receiving training.
- Provided Process Improvement Team training for state hospital leadership and staff on "Creating Violence Free and Coercion Free Mental Health Treatment Environments".
- Worked with the Office of Vocational Rehabilitation (OVR) to change policy to consider substance abuse as a disability and to include those that are dually diagnosed as a population eligible for OVR services if use is controlled and will not interfere with employment.

- Continued the growth of ACT to the point where we have 24 of the 31 providers with a certified ACT team.
- Held a statewide Cultural Competence conference.
- Held a statewide Faith-Based Initiatives conference.
- Consumer leadership courses were initiated by the DMHA Office of Consumer and Family Affairs with 3 consumers trained as trainers.
- Increased IMR sites and exceeded the target number of IMR sites.
- DMHA submitted an application under the SAMHSA Center for Mental Health Services Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention program, to establish the Indiana Youth Suicide Prevention Project.
- Held the 2nd Annual State Conference on Mental Health and Aging and initiated the Indiana Inter-College Council on Aging.
- Launched a statewide mental health screening for all children being placed in substitute care by the child welfare system, and forged a shared data agreement among Medicaid, child welfare and DMHA as a means to evaluate this initiative.
- A broad-based group has studied assessment instruments for children and recommended a tool that may be used across several youth-serving systems.
- Have served 29 children through the Home and Community-based waiver; six of these youth were taken out of state hospitals and four of the youth have graduated from waiver services.
- Children's Systems of Care are in various stages of development in 57 of Indiana's 92 counties, and served 3% of all children enrolled by service providers.
- DMHA staff, along with Department of Child Services staff, has presented information about our Child Welfare Screening Initiative at the national Child Welfare League Conference and at Children's Research Institute.
- Funded Indiana Federation of Families to offer technical assistance and support for development of family support groups, and to hold the first Family Conference.
- Held the first annual Women and Youth Recovery conference.
- Four "Behavioral Health Awareness for Terrorism and Disaster" trainings held for nearly 700 state personnel, emergency responders, and mental health providers.
- Systems of Care Technical Assistance Center made 396 site visits to the state's Systems of Care sites and trained system of care trainers through Georgetown Technical Assistance Center on "Coaching for Transformation".

The Indiana Division of Mental Health and Addiction is proud of the present mental health system and is dedicated to continued improvement of the system. Indiana has a history of promoting community based care and we will continue that effort.

PART B ADMINISTRATIVE REQUIREMENTS

Federal funding agreements, Certifications and Assurances

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2006

I hereby certify that _Indiana FSSA/DMHA_____ agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[1] will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2006, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

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21. The term State shall hereafter be understood to include Territories.

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:
(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

_____ August 26, 2005_____
Governor Date

Pages 10 – 16 are federally required certifications, disclosures, and assurances.

B. Certifications
http://www.mhbg.samhsa.gov/certification.pdf

C. Disclosure of Lobbying Activities
http://www.mhbg.samhsa.gov/disclosure.pdf

D. Assurances
http://www.mhbg.samhsa.gov/assurance.pdf

Public Comments on the State Plan
The Block Grant for fiscal year 2005 has been posted to the Division of Mental Health and Addiction website for public comment. Both the 2005 and the draft 2006 documents have been reviewed by the Mental Health Advisory Council, a public body separate from the planning committee. This Council endorsed the plan. No other public comment has been received.

During fiscal year 2006, DMHA will again post the plan to the web site with an invitation for comment. The DMHA Office of Consumer and Family Affairs maintains a large electronic distribution list (over 150 members) of individuals and organizations that have expressed an interest in receiving information about mental health. In January 2006, the current State Plan will be distributed to all members of this listserv with an invitation to comment on the plan prior to preparing the fiscal year 2007 document.

Set Aside for Children's Mental Health Services Report
FFY 2006

Data reported by State Fiscal Year
July 1, 2004 to June 30, 2005

	Base Year 1994	2004	2005
Block Grant Expenditures for Children	$ 2,875,417	$ 3,015,500	$ 3,000,000
State Funds for Children		$16,485,578	$16,446,296

MAINTENANCE OF EFFORT -- FFY 2006

Data reported by State Fiscal Year
July 1, 2004 to June 30, 2005

State Expenditures for Mental Health Services

2003	2004	2005
$111,822,862	$114,600,999	$113,211,931

State Mental Health Planning Council Requirements

1. **Membership requirements**
2. **Membership List and Composition**
3. **Planning Council Charge, Role and Activities**
4. **MHPC comments and recommendations (letter from chair)**

Table 1: List of Planning Council Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone & Fax
Ronda Ames	Consumer	Key Consumer Organization	2506 Willowbrook Pkwy, #199 Indianapolis, IN 46205 (317) 205-2500
Ruth Asher-Lynch	Advocate	Indiana School for the Deaf	1200 East 42nd Street Indianapolis, IN 46205 (317) 920-6355
Trace Benedict	Provider	Tri-County Opportunity School	599 S. Harbor Drive Noblesville, IN 46060 (317) 773-5321 ext. 101
Brandy Bledsoe	Consumer		8084 Wallingwood Drive Indianapolis, IN 46256 (317) 842-9079
Myra Bledsoe	Consumer		8084 Wallingwood Drive Indianapolis, IN 46256 (317) 842-9079
Susanne Blix, MD	Provider	IU School of Medicine	702 Barnhill Dr Indianapolis, IN 46202 (317) 274-4065
Sabina Calhoun	Provider	Mental Health Association in Indiana	1431 North Delaware Street Indianapolis, IN 46202 (317) 276-9199
Lisa Carrico	State Employee	LaRue Carter Hospital	2601 Cold Spring Road Indianapolis, IN 46202 (317) 941-4160
Margaret Carrico	Advocate	Eli Lilly & Company	2458 E. 500 N. Greenfield, IN 46140 (317) 276-9199
Wendell Chinn	Provider	Veteran's Administration	4424 Devon Drive Indianapolis, IN 46226 (317) 554-0000 ext. 4191
Dorothy Conklin	Parent of Child	Marion County Auditor	4811 Charney Ave Indianapolis, IN 46226 (317) 327-8638
Richard DeHaven	Provider	Center for Mental Health	POB 1258 Anderson, IN 46015 (317) 649-8161
Robert Denniston	Parent of Adult		2326 Dover Street Anderson, IN 46013 (765) 644-2988
Melissa Downton	Consumer	IRCIL Information & Referral Specialist	1426 West 26th Street Suite 207 Indianapolis, IN 46208 (317) 926-1660 ext. 225
Nancy Edgerton, Ed.	Provider	Hamilton Center, Inc.	620 8th Ave Terre Haute, IN 47804 (812) 231-8373

Name	Type of Membership	Agency or Organization Represented	Address, Phone & Fax
Roger Fisher, Jr.	Provider	Indianapolis Psychiatric Associates	8820 S. Meridian St., #255 Indianapolis, IN 46217 (317) 865-6922
Mike Flores	Advocate	IN Developmental Training Center	11075 N Pennsylvania St Indianapolis, IN 46280 (317) 815-0505
Brenda Hamilton	Parent of Child	Indiana Federation of Families of Children's Mental Health (IFFCMH)	2205 Costello Drive Anderson, IN 46011 (765) 643-4357
Myrna Hobbs, MSN	Advocate		5219 N. Kenwood Avenue Indianapolis, IN 46208 (317) 253-1961
Jim Hurst	State Providers Representative	IN Council of Community MH Centers	101 W Ohio St, #610 Indianapolis, IN 46204 (317) 684-3684
Elizabeth Krajeck	Parent of Adult	Housing & Urban Development	4911 N. Kenwood Avenue Indianapolis, IN 46208 (317) 253-5452
Winston Larry	Provider	Edgewater Systems for Balanced Living	1100 West 6th Ave Gary, IN 46402 (219) 885-4264
Mary Beth Lippold	State Employee	Department of Child Services	402 W. Washington St. W392 Indianapolis, IN 46204 (317) 232-4423
Sue Lummus	State Employee	Division of Mental Health & Addiction	402 W. Washington St., W353 Indianapolis, IN 46204 (317) 232-7824
Virgil Macke	Provider	Hamilton Center	2849 E Northwood Ave Terre Haute, IN 47805 (812) 231-8345
Charles Matsumoto	Advocate		849 Reda Road Indianapolis, IN 46227 (317)888-8505
Pamela Morrison	State Employee	Indiana Housing Authority	1919 N Meridian St Indianapolis, IN 46202 (317) 261-7268
Kathleen O'Connell, Ph.D.	Advocate	Associate Dean, School of Health sciences	2101 E. Coliseum Blvd., IPFW – IUPUI Fort Wayne, IN 46805 (260) 481-5795
Keith Oldknow	Consumer	Adult and Child Mental Health Center	8320 Madison Avenue Indianapolis, IN 46227 (317) 893-0334
Jami Perkins	Parent of Child	Indianapolis Bi-Polar	142 South Emerson Indianapolis, IN 46219 (317) 351-1082

Name	Type of Membership	Agency or Organization Represented	Address, Phone & Fax
Craig Peterson	Parent of Children	Families Reaching to Rainbows	4701 Langwood Court Indianapolis, IN 46268 (317) 872-2870
Deborah Pope	Consumer		900 Noble Run #D Noblesville, IN 46060-5224 (317) 770-0645
Anita Price	Advocate	AARP	124 Dominion Drive Zionsville, IN 46077 (317) 873-3400
Dennis Rhyne, MD	State Employee	Office of Medicaid Policy & Planning	402 West Washington St, W382 Indianapolis, IN 46204 (317) 233-5725
Becky Richardson	State Employee	Indiana Housing Finance Authority	115 W Washington St Indianapolis, IN 46204 (317) 232-7754
David Rollock, PhD	Advocate	Purdue University	Dept of Psychological Sciences W. Lafayette, IN 47907 (765) 494-6996
Nathan Rush	Advocate	Bethlehem House	8577 One West Drive #104 Indianapolis, IN 46260 (317) 466-7722
Sven Schumacher, MSW	Provider	Lutheran Child & Family Services	1525 North Ritter Ave Indianapolis, IN 46219 (317) 353-8211
Clare Skeehan	Consumer		1124 N. Whitcomb Ave, Apt. B Indianapolis, IN 46224-6721 (317) 487-2194
Judy Spray	Advocate	Marion County Public Defender Agency	129 E Market, # 700 Indianapolis, IN 46204 (317) 327-4100
Demaris Stewart	State Employee	Department of Education	Room 229, Statehouse Indianapolis, IN 46204 (317) 232-0570
Sharese A. Swafford, LMHC	Provider	Oaklawn Mental Health Center	POB 809 Goshen, IN 46527 (574) 537-2630
Karen Swarts	State Employee	Vocational Rehab Services	402 W. Washington St, W453 Indianapolis, IN 46204 (317) 232-1307
Phil Taggart	Consumer		4701 N. Keystone Avenue Suite 150 Indianapolis, IN 46205 (317) 205-8303
Rick Thomas	Consumer	Key Consumer Organization	2506 Willowbrook Pkwy. #199 Indianapolis, IN 46205 (317) 205-2500
Harold Thompson	Provider	SENIORS UNLIMITED	11711 North Meridian St. #580 Carmel, IN 46032 (317) 843-5280

Name	Type of Membership	Agency or Organization Represented	Address, Phone & Fax
Marge Towell-Cheesman	Advocate		10160 Basalt Court Noblesville, IN 46060 (317) 774-1041
Gabe Valenzuela	Provider	BehaviorCorp, Inc.	697 Pro-Med Lane Carmel, IN 46032 (317) 574-0055
Valeria Vaughn, RCD	State Employee	Vocational Rehabilitation	3607 West 16th Street, A-3 Indianapolis, IN 46222 (317) 232-1571
Deborah Washburn	Parent of Child	NAMI Indianapolis	3665 Power Dr Carmel, IN 46033 (317) 844-4047
Teresa White.	Advocate	Bethlehem House Channels of Hope	130 East 30th Street Indianapolis, IN 46205 (317) 923-5514
Christina Williams	State Employee	Department of Correction	302 W. Washington St. E334 Indianapolis, IN 46204 (317) 232-5706
Gilbert Winkel	Parent of Adult	Retired	4505 Mayfield Dr Kokomo, IN 46901 (317) 452-1207

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	55	
Consumers/Survivors/Ex-patients (C/S/X)	9	17%
Family Members of Children with SED	5	9%
Family Members of Adults with SMI	3	6%
Vacancies (C/S/X & family members)	0	0%
Others Not state employees or providers)	12	23%
TOTAL C/S/X, Family Members & Others	29	55%
State Employees	10	18%
Providers	14	26%
Vacancies	0	0%
TOTAL State Employees & Providers	24	45%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State employee and provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and elated support services.

Indiana State Mental Health Planning Council

Article I -Name

The name of this unincorporated association shall be the Indiana State Mental Health Planning Council (the "Council").

Article II -Purpose

The purposes of the Council shall be: (1) to exchange information and develop, evaluate and communicate ideas about mental health planning, (2) to write and/or amend the Federal Mental Health Services Block Grant plan for mental health services in the State of Indiana and recommend the plan to the Indiana Division of Mental Health and Addiction, (3) to advise the Indiana State Government concerning proposed and adopted plans affecting mental health services provided or coordinated by the state and the implementation thereof, (4) to monitor, review and evaluate the allocation and adequacy of mental health services in Indiana and to advise the Indiana state government concerning the need for and quality of services and programs for persons with mental illness in the state, and (5) to develop and take advocacy positions concerning legislation and regulations affecting mental health.

Article III –Membership

Section 1. Qualification

Council membership composition shall follow the guidelines set forth in P.L.102-321 and any subsequent federal regulations pertaining to council membership. The Council shall determine Status as a "provider" of mental health services upon recommendation of the Nominating/Membership Committee. Such determination shall be made upon recommendation of appointment by the Council and may be changed upon receipt of new or changed information. In order to facilitate such determination, applicants for and members of the Council shall be required to disclose to the Nominating/Membership Committee any work regularly performed for pay as or for a provider of mental health services.

(a) Organizations or individuals that spend 50% or more of their budget or paid time providing mental health services shall be considered as providers.
(b) Volunteers and advisory and governing board members shall not be considered as providers solely because of such status.
(c) Under general ethical principles, members of the Council shall excuse themselves when they have a direct financial stake in the outcome of a Council decision, independent of their status as a provider.

Section 2. Appointment

Membership shall be by appointment of the Director of the Indiana Division of Mental Health and Addiction or their designee. From time to time, the Council may recommend appointment of new members or removal of existing members. Failure of the Director or designee to veto such recommendation within thirty days of mailing shall constitute approval of the recommendation.

Letter from Mental Health Planning Council

2nd page of letter

Part C State Plan

SECTION I.
DESCRIPTION OF STATE SERVICE SYSTEM

Governor Mitch Daniels and his Administration are committed to building a mental health system that is compassionate, consistent, proactive and accountable. The **mission** of the Indiana Family and Social Services Administration is *to lead the future of healthcare in Indiana by being the most effective health and human service agency in the Nation.* The **major objectives** are: a consumer centric system, forging key alignments, creating a proactive state role, ensuring statewide implementation of best/promising practice service models, measuring and making known our results, leveraging technology and speeding the knowledge transfer from science-to-service.

Organization of the SMHA
The Division of Mental Health and Addiction is located within a larger agency, Family and Social Services Administration (FSSA). With the election of a new state administration in 2004, there have been significant changes in the organizational structure of the Family and Social Services Administration. The reorganization has created a separate cabinet level department for child welfare, the Department of Child Services (DCS). A separate Division of Aging has been created. In addition to a division for aging, the Family and Social Services Administration includes the Office of Medicaid Policy and Planning, Division of Disability and Rehabilitative Services, Division of Family Resources and the Division of Mental Health and Addiction. The divisions report to the FSSA Secretary, who is a member of the Governor's cabinet.

The Division of Mental Health and Addiction is actively involved with the Department of Correction (DOC) in several areas including monthly summit meetings and ongoing meetings on children's issues. This office has been working with DOC on the development of community corrections programs that will include mental health treatment. Work has also started to develop an initiative for prisoners with mental illness and/or addiction as they re-enter the community.

DMHA has participated as a "core partner" with the Indiana State Department of Health in planning for a more comprehensive early childhood system. In this process state agencies, community partners and families collaborate to develop a strategic plan leading to a coordinated, comprehensive, community-based system of service for young children. This process is supported by a planning grant from the Federal Maternal and Child Health Bureau. DMHA is also working with the Department of Health in the provision of disaster and terrorist planning.

DMHA is represented on the Governor's Interagency Coordinating Council on Infants and Toddlers, First Steps state panel and Head Start state panel, the Drug Endangered Child Task Force, Transitioning Youth Planning Group (Department of Education, Vocational Rehabilitation, Department of Workforce Development), and the planning

group that is writing the recently legislatively mandated Comprehensive Children's Social, Emotional and Behavioral Plan.

The Division is represented on the Interagency Council on Homelessness and has been actively involved in the preparation of the Indiana plan to end chronic homelessness. The Division is also represented on the Indiana Low Income Housing Trust Fund Advisory Committee.

Description of the State Mental Health System

The Division of Mental Health and Addiction (DMHA) contracts with privately owned, not-for-profit mental health centers for the provision of care. The guiding plan for mental health services is the Hoosier Assurance Plan (HAP) as developed following mental health reform legislation in 1994. That reform and the resultant HAP substantially changed the relationship DMHA has with the provider system. The DMHA funding system is a payment system based on enrollment of and services for a targeted population: those with a SED or SMI at or below 200% of poverty. This focuses our funding on the poor and enables DMHA to assure that treatment funds are used for the neediest population.

The contracted providers have over 200 service sites throughout the state. We are very proud to say that the penetration rates in rural Indiana are equal to the penetration rates in urban Indiana.

The HAP eliminated the traditional catchment areas and encouraged the development of multiple service providers in many areas. This has produced more consumer choice as there is more than one provider from which to choose in many areas of the state. In some of the more populated areas of the state there are four or more providers from which to choose.

Indiana providers are required by law and by contract to provide a Continuum of Care that delineates the full array of services that are to be available to everyone enrolled in treatment services. The Continuum of Care has been further defined in certification rules. The Continuum of Care will be discussed in more detail in both the adult and children's Section II. Case management, a required part of the continuum of care is also defined in Indiana Code and further regulated by rule. This will also be further discussed in Section II.

The DMHA instituted a gatekeeper practice wherein the mental health centers are responsible for an individual's entry into and exit from a State Psychiatric Hospital. The referring mental health center is required to participate in the treatment planning and discharge planning for persons admitted to a State Psychiatric Hospital from the community. This has created a system in which people referred to a state facility are not placed and forgotten. This has also created a closer tie between the state hospital and the mental health centers. A children/youth Level of Care application was adopted in 2003 to assist children's gatekeepers in determining if sufficient community-based interventions had been tried before hospitalization.

This office has assigned to each provider a number of State Hospital beds that they can use. The allocation is based on the population in need of services in an area. This has created a system where each provider has a limited number of beds to use and eliminates the overuse by any one provider. We presently have 690 state hospital beds allocated to the community mental health centers. The number of beds is not static since the availability of beds is influenced by the number of admissions that are not under the control of the mental health centers such as outdates from corrections, forensic admissions, and admissions of persons with mental retardation/developmental disabilities from other state institutions that are being closed.

The development of Children's Systems of Care has been seeded by state funding since 2000, and approximately 60% of the state now has some level of system of care development in place. Indiana is home to 2 federally funded Systems of Care sites; the Dawn project in Marion County and Circle Around Families in Lake County, both of whom are successfully completing their final grant-funded years. During SFY 2005 over 900 children/youth and their families were served by Systems of Care. The state-funded Technical Assistance Center for Systems of Care and Evidence-based Practices supports the movement through coaching, training, assessment and dissemination of the theory of change.

The DMHA Office of Emergency Management and Preparedness has developed short-term interventions with individuals and groups experiencing psychological responses to large-scale disasters. The Office has also developed an All Hazards Emergency State Plan as a mental health standard for the state. They collaborate with the Indiana State Department of Health, and have secured a $100,000 grant from the Center for Mental Health Services to provide disaster training. They have trained nearly 700 mental health and health professionals across the state on Behavior Aspects of Disaster and Terrorism. Portions of this training deal with family and child/youth needs.

DMHA has long been concerned about the provision of treatment that is culturally competent. All providers have made use of training that has been offered via contract with a training agency. Internally, a DMHA Cultural Competency committee monitors our needs and growth areas as a staff. Indiana, as host to nationally noted Black Expo, plays an important role in recognizing the many and diverse cultures in our state. FSSA, through DMHA, is an active participant in many of its events, including the youth summit, which engaged 360 young people in 2005. During SFY 2005, 240 persons received cultural competence training. An additional 260 persons participated in a two day conference "Bridging Cultures with Competence".

DMHA has established partnerships with local and state faith based organizations in order to promote interconnectivity between the mental health and addiction system and these organizations that have extensive contact with consumers. The partnerships have several goals including identification of mental illness and addiction, dissemination of information regarding referral procedures, increasing awareness of appropriate treatments, and encouraging greater levels of collaboration and consultation. The first,

highly successfully "Faith Healing and Hope" Conference was held, to celebrate treatment and recovery and had 275 persons attending. The newly established Governor's Office of Faith and Community-based Initiatives further supports the role of cultural competence.

In 1994, one state hospital was closed and virtually that entire budget was moved to the community based treatment budget. We have continued to downsize state hospitals and move budget savings to the community.

The Community Services Data System was instituted in 2001. This is a consumer based data system that collects detailed demographics and diagnostic information from all treatment providers. It also tracks treatment encounters over the course of treatment for each individual served by the funded providers in Indiana. It has greatly increased our understanding of the services provided and has made it possible to comply with the Mental Health Block Grant requirements for data collection.

Last year the Indiana plan review resulted in three written modifications being required.

1. submit to CMHS additional information regarding training of providers of emergency healthcare,
2. submit a plan to CMHS to provide core performance indicator data regarding hospital admissions in this year's implementation report, and
3. submit a plan to have the planning council be in compliance with the block grant requirements regarding adequate representation by consumers and state employees.

All three of these were included in our response to CMHS. A earlier survey of providers showed active training of local emergency room personnel and local law enforcement in the handling and appropriate response to the needs of persons with mental illness. In many instances the local mental health center provides staff to the local hospital or has staff on call to respond as needed. Indiana is prepared to provide the data on state hospital readmissions per the data required in the December Implementation Report. Additionally, there is a new goal statement in both the Adult and Children plan regarding readmissions. A member of the DMHA staff has been added as a voting member to the State Mental Health Planning Council.

The DMHA Consumer Council, which is supported by the DMHA Office of Consumer and Family Affairs, voted earlier this calendar year to join the State Mental Health Planning Council. The merger of these two councils has added more consumer and family voice to the planning council. In order to preserve the Consumer Council identity, it continues to have three meetings per year in addition to the regular quarterly planning council meetings. The Consumer Council has also recruited three youth/young adults as members. Each of these individuals has first-hand experience with services for children and adolescents. The Consumer Council is currently working on a position paper regarding Recovery which should be available in the fall of 2005 for distribution.

We continue to see increases in our involvement in Evidence Based Practices especially Assertive Community Treatment, Illness Management and Recovery and Integrated Dual Diagnosis Treatment. There are twenty agencies that are funded ACT pilot sites and an additional three agencies have added ACT without special funding. The Indiana Medicaid rule was changed to include a daily rate for ACT. The Division expects continued growth in the area of ACT as more programs begin or expand the number of ACT teams. There are seven pilots involved in IDDT. We will be implementing IMR at six pilot sites over a two year period under a SAMHSA grant.

There are a limited number of Evidence Based Practices for children. Researchers consistently describe Systems of Care as a promising practice. The Systems of Care Technical Assistance Center has begun work with Indiana's system of care sites to help them define their practice model and to subsequently develop fidelity practices. Measurement of fidelity will be accomplished through use of the Wraparound Fidelity Index. Information from the fidelity measurements will then be utilized for system improvement. As fidelity and outcome data are collected on a wide variety of services delivered throughout Indiana, effective models of care will quickly emerge. These models can then be shared and implemented in other communities.

Supported employment has been in existence for almost twelve years in Indiana. At this time there are 27 mental health centers that provide supported employment. Changes in the client based data system (CSDS) beginning in state fiscal year 2006 will create a better focus on supported employment and employment outcomes as the result of employment programs. Additionally, the Office of Vocational Rehabilitation, which is within the FSSA Division of Disability and Rehabilitative Services, is taking an in-depth look at employment outcomes for all agencies involved in supported employment.

Indiana was awarded a 1915(c) Home and Community-based Medicaid Waiver in 2004 for children with serious emotional disorders. The waiver provides a community-based option for children who are eligible for state hospital admission.

Legislative issues

Legislation was enacted to create a new Department of Child Services which has responsibility for reshaping the state's child welfare policy and practice. The legislation also requires the department of child services, the department of education, the department of correction, and the division of mental health and addiction to develop and coordinate a comprehensive children's social, emotional and behavioral health plan. This plan is due to the legislative services and the mental health commission by June 1, 2006.

In response to two incidents in which law enforcement officers were killed by persons with histories of mental illness, legislation was introduced to allow seizure of firearms from persons suspected of being mentally ill and dangerous. Advocates for persons with mental illness worked with the legislature to revise this legislation to broaden the statute to include anyone reasonably considered dangerous by the law enforcement officer.

DMHA has led a cross-system initiative that launched an Early Identification and Intervention initiative to provide mental health and addiction screening to all children in the child welfare system that are placed in substitute care. The systems partners are: Family and Social Services Administration, Division of Family Resources, Department of Correction, Department of Special Learners, Juvenile Justice Improvement Committee, State Budget Agency, the Indiana Federation of Families and Department of Child Services. This initiative lead to the creation of data sharing among DCS, Office of Medicaid Policy and Planning and DMHA.

DMHA convened a group of providers, practitioners, educators, and families to study assessment tools for children that could be used across systems for community planning, informing decision making and treatment planning. During the eight month process, the group worked on further defining the objectives of assessments. Their recommendations have been presented to the Children's Comprehensive Social, Emotional and Behavioral Health Plan group which has endorsed the recommendations.

The Future of Indiana's Mental Health System

DMHA and its parent agency (FSSA) have fully embraced the need for system transformation. The state has submitted a grant application for federal funding of the state's transformation effort. The state is fully committed to moving forward with a re-examination of the system including how it is funded, what is being purchased by the state, and the effectiveness of the services being purchased. This transformation process will align the state with the recommendations in *Achieving the Promise: Transforming Mental Health in America* and promises to bring needed changes to the interactions between the state and the providers and recipients of services with emphasis shifting to a consumer centric system.

SECTION II (ADULTS)
IDENTIFICATION AND ANALYSIS OF THE SERVICE SYSTEMS STRENGTHS, NEEDS, AND PRIORITIES

Criterion 1
Comprehensive Community Based Mental Health System

Organizational structure of the system of care

Indiana maintains a statewide mental health service system by contracting with thirty-one private not-for-profit community mental health centers that provide a full continuum of care in all areas of the State. There are over 200 service sites throughout the state.

Through the 1991 Mental Health Reform Legislation the Division of Mental Health and Addiction (DMHA) implemented the Hoosier Assurance Plan. The Hoosier Assurance Plan eliminated the traditional service areas for providers in order to increase consumer choice of providers. The Hoosier Assurance Plan also changed the funding system and added levels of accountability for services provided.

DMHA developed a gatekeeper system for admission to and discharge of an individual from a state operated facility. This defines the relationship between the state operated hospital system and the state supported community mental health center system. The thirty-one community mental health centers are required to serve as the gatekeepers for State Hospital admissions and discharges and the admitting mental health center is required, by rule, to be involved in the treatment of an individual during hospitalization and to participate in the discharge planning. We formalized the gatekeeper role by promulgating a rule that defines, in administrative code, the responsibilities of the gatekeeper. The mental health centers and the State Hospitals are now acting more in concert in the return of individuals to the community.

Through a bed allocation process, DMHA assigns to each mental health center the number of state hospital beds they will be able to use during a fiscal year. This allocation is based on the population base of the provider and the number of persons served in the previous year. This has leveled the use of the state hospital beds by the providers.

The CMHC's are required by Indiana Code (IC 12-7-40.6) and by contract to provide a defined Continuum of Care. Continuum of care means a range of services, the provision of which is assured by a community mental health center or a managed care provider. The term includes the following:

1. Individualized treatment planning to increase patient coping skills and symptom management, which may include any combination of the services listed under this section.
2. Twenty-four (24) hour a day crisis intervention.

3. Case management to fulfill individual patient needs, including assertive case management when indicated.
4. Outpatient services, including intensive outpatient services, substance abuse services, and treatment.
5. Acute stabilization services including detoxification services.
6. Residential services.
7. Day treatment.
8. Family support.
9. Medication evaluation and monitoring.
10. Services to prevent unnecessary and inappropriate treatment and hospitalization and the deprivation of a person's liberty.

In addition to the Continuum of Care, Community Support Services are a mandated service. Community Support Services require coordinated case management services, outreach, assessment and diagnosis, crisis intervention, psychiatric treatment including medication intervention and supervision, counseling and psychotherapy, activities in daily living training, psychosocial rehabilitation services, client advocacy, residential services, recreational activities, vocational services, and educational services. Community Support Services are also responsible for the admission and discharge planning of persons entering and returning from the state hospitals.

Evidence Based Practices

In 1999, DMHA decided to promote the development of Assertive Community Treatment. To assist in developing ACT, DMHA sought out the assistance of Dr. Gary Bond. We funded the ACT Technical Assistance Center headed by Dr. Bond at Indiana University Purdue University at Indianapolis. The Center provides regional training events, maintains a web site, publishes an ACT newsletter, provides job shadowing, and generally works with and assists the development of the ACT model.

In 2000, this office standardized Assertive Community Treatment (ACT) in the state. We defined Assertive Community Treatment in Indiana and we have promulgated the ACT rule. This process started with a meeting of the researchers with Dr. Bond's team, DMHA staff, providers, consumers and family members. The framework for the present rule was established through a series of meetings with this group.

Through funding a series of ACT pilot sites, we have 20 funded sites along with five other centers that decided to develop ACT teams without funding. There are 25 of 31 CMHC's that have certified ACT teams. Two centers are in the process of adding new ACT teams and one will be developing an ACT team that specializes in the dually diagnosed. Another provider is discussing with the local law enforcement agencies the potential of developing a forensic ACT team to work with those that are being released from jail or are being placed on probation or parole.

As of June 2004, ACT has been added to the State Medicaid Plan. An ACT policy and daily rate have been implemented.

There are seven pilot sites participating in the Dartmouth Integrated Dual Diagnosis Treatment (IDDT) tool kit. The ACT Center is providing the training and monitoring of these projects. There are several other centers that are moving to IDDT.

DMHA, in conjunction with the ACT Center, was successful in getting a SAMHSA grant to develop Illness Management and Recovery (IMR) at six sites. The second year application has been funded. The ACT Center is providing the training and monitoring of this project.

Supported Employment (SE) has been in operation in Indiana for twelve years. The design of the Indiana SE could easily be moved to fit the definition of an EBP, and we are experimenting with that concept. SE is discussed more fully later in this section.

The Indiana NAMI has been providing the Family to Family education series for several years. This is considered as part of the EBP Family Psycho-Education. This effort, funded by DMHA, is considered a move toward implementing the evidence-based practice.

Beginning in state fiscal year 2006, information at the individual consumer level is being reported for IDDT, IMR, and Supported Employment by the mental health centers. This data collection is in addition to previously collected information regarding ACT services. Family Psycho-Education data is not collected since the NAMI program is not individual consumer specific

We are providing and collecting client level data for four of the six EPB's. The challenge will be ensuring continued growth for the IMR and IDDT pilot projects. ACT and Supported Employment are solidly in place. The current method for providing Family Psycho-Education does not lend itself to collecting client level data at this time. DMHA and NAMI-Indiana will initiate discussions regarding data collection during this fiscal year in order to determine if an appropriate data collection methodology can be identified.

Based on the rapidly growing body of research, consumers in the state are advocating that Consumer-Operated Services be considered an EPB and that DMHA begin to provide funding for implementation of these services. Supported Housing is another emerging evidence-based practice for which the state has not adopted a standard model. Many providers offer some form of housing plus support. As the Supported Housing toolkit is made available, DMHA will make the information available to the provider community.

Available system of treatment, rehabilitation, and support services

All community providers are involved in rehabilitation and employment. Those with supported employment programs are more formally involved in the provision of employment services.

In 1994 we closed a state hospital and had available state funds for the development of additional community based services. The DMHA and the Office of Vocational Rehabilitation (OVR) established a series of grants to create supported employment

programs for those leaving the closing hospital. This office was able to use the new state funds as match for federal funds available to OVR. That started the establishment grant series that was used to develop supported employment at 27 mental health centers.

As we began the establishment grants, we used the same funding arrangement with OVR to fund the Supported Employment Consultation and Training Center (SECT) at the Center for Mental Health, Inc. in Anderson, Indiana. The SECT center is a provider of technical assistance to providers interested in developing or improving supported employment efforts. They continue to be very active in providing training to the newly funded supported employment projects. One added component of the grant is data collection. This consists of collecting information on the numbers of persons entering supported employment, their wages, cost of supported employment counseling, the average time worked, the average wage, benefits and many other areas.

At this time we have 27 mental health centers that are providing supported employment under a contract with OVR. The ACT certification rule mandates that there be a supported employment program present and that there be an employment specialist on the ACT team.

In 2001, legislation was enacted that changed the Indiana Medicaid rules to allow for a Medicaid buy-in program. This program called MEDWorks enables persons with a disability to continue Medicaid coverage by paying a premium to Medicaid based on their monthly income to help offset the cost of the program. People on Medicaid no longer need fear loss of Medicaid and many now working at lower pay levels are able to accept a pay increase, promotions and additional hours.

For several years DMHA has been working with a committee that is exploring supported education. That effort lags behind the supported employment success but surveys of consumers, providers and educators indicate there is potential for expansion in this area. The OVR continues interest in this project and has been involved in the committee work. A recent analysis of persons between the ages of 14 and 30 who are receiving public mental health and addiction services in Indiana revealed that two issues significantly separate these individuals from the general population within the same age range. These two issues are education and employment, both of which have significantly lower rates for persons being served in the public system. This analysis supports the need to emphasize implementation of and continuation of Supported Education and Support Employment programs.

Description and definition of case management system

Case management services are goal oriented activities that assist individuals by locating, coordinating and monitoring necessary care and services appropriate and accessible to the recipient. The major components of service are essential to reducing the impact of handicaps or disabilities experienced by the person served. This service is to be available 24 hours per day, seven days per week. Any individual who meets the definition of having a serious mental illness is eligible for case management.

Indiana Code defines case management services in Chapter 19. "Community Care for Individuals with Mental Illness".
"Sec. 2. (a) As used in this chapter, "case management" means goal oriented activities that locate, facilitate, provide access to, coordinate, or monitor the full range of basic human needs, treatment and service for individual patients.
(b) The term includes where necessary and appropriate for the patient the following:
(1) Assessment of the consumer.
(2) Treatment planning.
(3) Crisis assistance.
(4) Providing access to and training the patients to utilize basic community resources.
(5) Assistance in daily living.
(6) Assistance for the patient to obtain services necessary for meeting basic human needs.
(7) Monitoring of the overall service delivery.
(8) Assistance in obtaining the following:
    (A) Rehabilitation services and vocational opportunities.
    (B) Respite Care.
    (C) Transportation.
    (D) Education Services.
    (E) Health supplies and prescriptions."

We have also established a rule for the provision of case management. That rule covers in detail the minimal standards for the provision of case management by the mental health centers. The rule is inclusive of the mandates of the above law and provides more measurable components and eliminates much of the areas that were open to interpretation under the law alone.

Historical reduction of state hospital beds and changes in utilization of psychiatric inpatient in other settings

In 1994 this office closed a state hospital located in Indianapolis. The state funds used to operate that institution were moved to support community based services. To evaluate the effects of this closure, this office funded research over ten years to track all of the individuals who were at that hospital at the time of the closure. This research measured many quality of life issues and the researchers maintained contact with nearly all of 400 individuals present at the hospital closing. In addition, the research tracked former employees of the hospital to examine the effect of the closure on them. There have been regular reports by the researchers including annual reports on the data collected. A series of articles based on the data collected appeared in *The Journal of Behavioral Health Services & Research*, August 1999, Volume 26/Number 3. This research project is now completed and we are awaiting final reports from the researchers.

Description of Substance Abuse Services for Adults with Serious Mental Illness

All mental health centers in Indiana provide substance abuse services. However, not all have developed integrated programs for the person with SMI who is also using

substances. A survey of providers indicated that 14 of the 30 providers have an identifiable dual diagnosis track for consumers.

Indiana is involved in the Dartmouth Dual Diagnosis tool kit project. We are working with the Technical Assistance Center at Indiana-Purdue University at Indianapolis on this project. Seven mental health centers have agreed to be part of the project and will be establishing integrated services for the dually diagnosed according to the tool kit. One of the concerns about this is the ability of DMHA to create a funding stream that is dedicated to the support of IDDT. There are many providers that have moved to IDDT. This will be captured in the new data requirements for state fiscal year 2006.

Housing

The mental health centers, as a requirement of the Continuum of Care, are responsible for residential services. Some have been very active in securing HUD financial assistance to develop a range of residential options. Some have been awarded Shelter Plus Care grants. This office has had a number of events to encourage the providers to be better able to seek funding. We have taken steps to insure that providers participated in the Consolidated Plan and in the Continuum of Care application.

Housing continues to be a major concern for all providers. This office shares that concern and we have developed a Housing Action Team that is examining the existing housing options and examining ways to assist providers in creating more housing options.

Medical and Dental services

Mental health centers are required by rule to complete a physical health screen with referral for a physical examination when clinically indicated. Additionally, in the normal course of treatment the consumer often asks for assistance in securing any medical or dental assistance. For residential care, the rule states that the provider must assist the resident to obtain medial and dental care.

Office of Family and Consumer Affairs

In the amendment of the 2000 Block Grant Plan this office decided to use the increase in Block Grant funds to establish an office of consumer affairs. That position remains and has proven to be an asset to this office. The purpose of the Office of Consumer and Family Affairs is to empower consumers and family members by assuring their interests are represented and their input is considered in DMHA planning and policy development.

The goals for the Office of Consumer and Family Affairs for the coming year are:
1. To provide an “internal” voice for consumers and family members within DMHA.

2. Liaison with consumer and family organizations to establishing communications, identify major issues and concerns, and provide consultation, technical assistance, and ongoing support.

3. To develop, implement and monitor special projects, including a minimum of six annual focus groups to solicit consumer input on Olmstead planning and implementation.

4. Identify, train and involve a minimum of twelve consumers and family members annually in DMHA planning and policy development activities.

Services for the Elderly

2nd Annual State Conference on Mental Health and Aging

DMHA, the state aging agency, and the Indiana Coalition on Mental Health and Aging co-sponsored the 2nd Annual State Conference on Mental Health and Aging. Approximately 100 participants, primarily from the mental health system and the Aging Network, attended the conference. Nationally known leaders from the field including Steve Bartels, MD, from Dartmouth, the aging consultant to the President's New Freedom Commission on Mental Health, and Fred Blow, Ph.D. from the University of Michigan, the chair of the consensus panel that developed the SAMHSA CSAT *Substance Abuse Among Older Adults* (TIP #26), presented at the Conference. Six of Indiana's delegates, including a DMHA staff member, to the 2005 White House Conference on Aging also participated in the Conference.

Indiana Inter-College Council on Aging

DMHA took the lead in organizing the Indiana Inter-College Council on Aging. The purpose of the Council is to provide leadership and foster collaboration in gerontology research and education. The group started with the focus being on older adult mental health and substance abuse, but expanded its mission to include the broader range of aging. All of the major universities in the State, including Indiana, Purdue, Ball State, Notre Dame, Butler and IUPUI are active members of the Council. A DMHA staff member served as interim chair during the organizational phase and remains on the executive committee. The current chair is from the University of Indianapolis, who also hosts the meetings.

Medicaid Coverage of County Home Residents

Indiana still has 19 county homes which serve as the housing of last resort for poor elderly and disabled persons. Over the years the numbers of residents with mental illnesses has increased to a level causing concern. Although one of the eligibility requirements for entering the program is meeting Medicaid eligibility standards the medical services, including mental health services, for many years were paid out of state funds under the belief that individuals living in these "public institutions" were not eligible for Medicaid. The result was that many residents were not receiving mental health services since payment for these services were not included in the daily rate paid to the facility and other access to services issues. The Division took the lead in working with the Centers for Medicare and Medicaid Services (CMS) and it has been clarified that the residents are Medicaid eligible.

Older Adult Specialists at Community Mental Health Centers

For many years the DMHA has required community mental health centers to provide older adult services, to designate a contact person for older adult services, and to provide the federally mandated PASRR program. The Division works with the Older Adult Services Committee of the Indiana Council of Community Mental Health Centers to provide at least two training conferences annually. This year the Division obtained and distributed copies of the *Get Connected! Linking Older Adults with Medication, Alcohol, and Mental Health Resources.* This Tool Kit was developed by the National Council on the Aging through a SAMHSA grant. A DMHA staff member participated in the development of the Tool Kit and several Indiana programs are highlighted in the materials.

Indiana PASRR Program

Indiana has used the federally mandated PASRR program as an opportunity to identify nursing home residents with mental illness and to assist the residents in accessing services. DMHA works in partnership with the State offices for aging, health, and Medicaid to administer the program and to assure that nursing homes are following-up on PASRR service recommendations and are providing or arranging for services to meet the mental health needs of the residents. Indiana's program is viewed as a model and other states are frequently referred to Indiana by the Centers for Medicare and Medicaid Services for consultation and technical assistance. During the past year a DMHA staff member was invited by CMS to represent state mental health agencies on an expert panel to assess the first 15 years of the PASRR program.

Strengths and Weaknesses of the Indiana Adult Mental Health System

Strengths:

- We very proud of the statewide coverage that exists in which all 92 counties have access to mental health services and this is evidenced by the continuing penetration rates in rural areas of the state.
- We have a defined and required Continuum of Care and Case Management that provides the base of services for all mental health services.
- We instituted an Office of Consumer Affairs in 2001 and that continues to be a benefit to this office and the consumers in Indiana.
- There is a strong dedication to Evidence Base Practices as shown by our involvement in four EBP's.
- We have a strong history of supported employment with most of the providers participating in the model.
- The gatekeeper model and bed allocation have placed the mental health centers in a position where they are active participants in a persons stay in a state facility.

Weaknesses:

- We do not have strategy to fiscally continue EBP's and we are working to develop policies that will help offset that.

- "Outside" (primarily forensic and developmental disability) admissions to the state facilities are limiting the number of beds available to the community provider.

Criterion 2
Estimations of Prevalence and Mental Health Systems Data

Quantitative population targets to be achieved through implementation of the mental health system including estimates of numbers of individuals with SMI in the state and the numbers of such individuals served.

State Definition of SMI

Indiana Administrative Code (440 IAC 8-2-2) provides the definition of adults with serious mental illness as follows:

A) The individual is eighteen (18) years of age or older.
B) The individual has a mental illness diagnosed under the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association.
C) The individual experiences significant functional impairment in two (2) of the following areas:
    i) Activities of daily living
    ii) Interpersonal functioning
    iii) Concentration, persistence, and pace
    iv) Adaptation to change
D) The duration of the mental illness has been, or is expected to be, in excess of twelve (12) months. However, adults who have experienced a situational trauma do not have to meet the durational requirement of this clause.

This definition closely parallels the federal definition of serious mental illness and for purposes of reporting data regarding persons served in Indiana is considered equivalent.

Description of Estimation Methodology

The Division of Mental Health and Addiction uses two methodologies for estimating the prevalence of adults with Serious Mental Illness in Indiana. The first method is calculated using the Center for Mental Health Services methodology. The second method is based on the eligibility requirements for the Hoosier Assurance Plan, which established eligibility at or below 200% of the federal poverty level.

Center for Mental Health Services Methodology — Based on the *Federal Register* "final notice" of June 24, 1999: Estimation Methodology for Adults with Serious Mental Illness (SMI), the prevalence for Indiana adults with Serious Mental Illness is over 250,000 persons (see table below).

Population Prevalence Estimates at 200% FPL — The 2005 total number of adults aged 18 and above in Indiana based on projections from the 2000 census will be approximately 4,648,737. Also based on the 2000 United States Census reports, approximately 26% of Indiana's adult population has incomes at or below 200% of the federal poverty level.

The following table depicts the prevalence of adults with mental illness in Indiana based on the two estimation methodologies.

INDIANA ADULTS WITH SERIOUS MENTAL ILLNESS

Eligible for DMHA Services	66,129
CMHS Estimation Methodology	251,032
2005 Indiana Population aged 18 and above	4,648,737

Strengths:

- There have been steady increases in the numbers of persons served each year so that we have increasingly larger penetration rates.

Weaknesses:

- There has been no proportional increase in funding in response to the increased number of persons served.

Criterion 4
Targeted Services to Homeless Populations
Targeted Services to Rural Populations

Description of the homeless population

Estimates provided in the Indiana Continuum of Care indicated that there are 58,000 homeless in Indiana in a year's time. Of these, it is estimated that one third or 19,000 homeless individuals have a mental illness.

Description of available services

The client based data collection provides information on living situation that includes homelessness. All of the mental health centers report on services to the homeless population. Each mental health center has the capability of serving the homeless through a wide array of residential services. They do not necessarily have the capacity to serve everyone in need. Housing is usually an issue listed by the providers.

Description of PATH, Shelter Plus Care, and HUD grants

This office contracts with ten mental health centers to provide Homeless Outreach Teams through the PATH Grant Program. The teams are located in the most densely populated areas of Indiana: Central Indianapolis, Fort Wayne, Lake County (two centers), South Bend, Elkhart, Bloomington, Evansville, Anderson and Muncie. An increase in funding this year

will be used to fund innovative relationships with law enforcement or local hospital emergency rooms.

The teams provide the following services:

- Screening and diagnostic treatment services
- Habilitation/rehabilitation services
- Community mental health services
- Staff training
- Case management services
- Supportive and supervisory services in
- Residential services
- Referrals for primary health services
- Job training and educational services
- Housing services

All the PATH teams are a part of comprehensive community mental health centers and the full continuum of services are available to persons who are homeless that are enrolled in treatment services. All of the PATH sites have a certified ACT team operating in the agency. A history of homelessness is one of the ACT admission criteria.

The target population for the Mobile Homeless Outreach Teams is the homeless individual who is mentally ill and has problems that require professional intervention. Homeless has been defined as including individuals who:

1. May live on the street, in cars, or in abandoned structures or public places;
2. Are housed in emergency shelters and other places not considered home;
3. Are living with friends or relatives in crowded, unhappy, and stressful circumstances;
4. Are living in deteriorated, unsafe housing, often lacking utilities; or
5. Are involved in support programs without which they would be at high risk of homelessness. Some of these individuals may be "chronic" street people while some are on the streets on an episodic basis.

As part of the PATH grant application this office developed a definition of the “at-risk of homeless population”.

“A person at imminent risk of becoming homeless includes those who are:
- living with friends or relatives in a sequence of living arrangements
- living in a condemned building
- facing an eviction notice
- in a county jail with no housing available upon release
- in a psychiatric inpatient unit with no housing available upon release”

The PATH teams have established excellent relationships with the local shelters. In some cases this relationship has made it too easy for the PATH workers to find the homeless

and they were not "working the streets" as they used to do. This office made several visits to the PATH sites and encouraged a return to outreach to the homeless street people. Reports from those teams show that they are doing just that and they are enjoying the new focus.

This office created a policy that prohibits a discharge from state operated mental health hospitals to homelessness. That policy was reviewed and approved by the DMHA Policy Development Committee and distributed to all applicable agencies.

Shelter Plus Care has been successfully funded at seven mental health centers and one Mental Health Association.

While developing the Indiana Continuum of Care (as defined by HUD), this office agreed that all providers should have a service agreement with their local homeless shelter. This office surveyed all providers to determine the presence of an agreement with the local homeless shelter. The results of that survey showed that all mental health centers have an agreement with local shelters where there are shelters.

The Indiana Housing and Community Development Authority sponsors the Interagency Council on the Homeless (IAC) comprised of the highest level decision-makers from state agencies involved in homeless issues. The IAC has membership of the Housing and Community Development Authority, Department of Correction, Department of Veterans Affairs, Department of Health, and two offices of Family and Social Services Administration: the Division of Family Resources; and the Division of Mental Health and Addiction.

A subcommittee of the IAC attended *Improving Access to Mainstream Services for People Experiencing Chronic Homelessness*, a Policy Academy for State and Local Policymakers, in Chicago. As the result of that event, the subcommittee has published an Indiana *Action Plan to End Chronic Homelessness*.

Definition of rural locations in the state and description of the urban/suburban/rural mix

The Division has established a definition of rural: those counties with fewer than 100 persons per square mile.

As a result of the census of 2000, we remain a rural state but we have changed from 62 to 63 rural counties. The number of people living in rural counties has slightly increased by 0.64% (1,545,000 to 1,555,000) while the whole state increased by 9.7% (5,544,000 to 6,080,000). The percentage of people living in rural areas has changed from 27.8% to 25.6%.

This office did a survey of rural providers and several rural providers were interviewed to discuss the success of rural providers in the area of outreach and engagement of consumers in rural areas. Some providers are very active in the school systems, providing therapists who work with children. Most have increased the number of case

managers. Most believe that they have very good relationships with local Department of Child Services and Division of Family Resources offices and law enforcement. It became clear that the rural mental health centers are one of the major employers in the community and the rural providers have a higher level of standing and recognition in the community than do many of the urban providers. One provider commented that they have established auxiliary offices so that there is an office within 30 minutes of everybody in the service area. All interviewed said they had a high level of coordination with other service providers in the area.

This office is very proud of the rural coverage that exists. For the past several years we have monitored the levels of service in rural areas and found that penetration rates are virtually the same in rural areas as in urban areas.

Strengths:

- Increased PATH funds have made it possible to increase funding for the ten teams and to fund two innovative programs within PATH
- Rural penetration rates continue to be comparable to urban services indicating accessibility of services in all areas of the state.

Weaknesses:

- Many rural centers feel they do not have adequate numbers of people meeting the admission criteria of ACT to justify establishing that EBP.

Criterion 5
Management Systems

Financial and staffing resources…which will be needed to implement the plan.

The majority of the Block Grant funds are placed in the general treatment funding pool of DMHA. Funds are distributed to providers based on a funding allocation formula based on levels of services from the previous year. This system does not allocate Block Grant funds proportionally. At the end of the contract year we are able to track funding sources for each contactor so that we are able to show where Block Grant funds were expended. The planning committee would like to earmark some of the Block Grant funds for consumer operated programs. This will be explored during the coming year as all funds for this year have been allocated.

The state budget continues to be very tight with little hope of increases for mental health. There is presently a request that the divisions of FSSA identify dollars that can be placed in reserve as the administration monitors the economy and budget situation. As in the past we will make every effort to make the cuts in non-treatment funds and protect treatment funds.

The following table represents the various funds available for the purchase of services for the SMI population. Not shown on this table are the federal Medicaid Rehabilitation Option funds that the providers access during the year.

Comparison of DMHA Funds for Mental Health Centers for SMI Services
State Fiscal Year 03 to 05

	Adult Services	Social Services Block Grant	Mental Illness Block Grant	TOTAL
SFY 03	$75,855,836	$3,694,164	$3,000,000	$82,550,000
SFY 04	$75,984,704	$3,565,296	$3,000,000	$82,500,000
SFY 05	$77,219,397	$4,617,409	$4,148,144	$85,984,950

Description of the role of the MHBG program in the state, including innovative services funded by the grant.

The block grant funds, for adult services, are used for the purchase of community based services provided by the mental health centers.

While not directly related to the block grant funds, this office is also funding the KEY Consumer Organization for the development of advocacy groups and NAMI Indiana for the purchase of Family to Family training for families and others involved or affected by mental illness. We also fund the ACT Center that provides technical assistance and training for the developing ACT teams.

Emergency Health providers

All providers have a close relationship with local emergency providers. In some instances there is staff from the mental health center at the ER to assist in evaluations. One provider noticed problems with law enforcement and the transportation of individuals to court. They trained a small group of law enforcement officers who now volunteer for transportation duty. This has reduced the trauma of such transportation. Another provider, more than 15 years ago, started training local law enforcement and emergency responders following an airplane crash in their area. Several agencies have adopted the Memphis model. There are also providers that have established mobile crisis units that respond with law enforcement when called on a disturbance involving a potentially mentally ill individual.

Emergency response personnel receive training from the State Emergency Management Agency (SEMA). SEMA contracts with a community mental health center to provide to emergency response personnel Crisis Counseling Intervention techniques. Since 9/11 the Governor created the Homeland Security Agency (HSA) for Indiana, to respond to terrorist activities that may affect citizens, business, and government activities.

There is a cooperative agreement between the Indiana Department of Health (ISDH) and the Centers for Disease Control and Prevention (CDC) that recognizes the requirements to address needs and direct activities to issues of psychological health and their behavioral manifestations. The Division of Mental Health and Addiction, in partnership with the Indiana Department of Health is responsible for administering the State's program for the psychological health of those Indiana residents potentially victimized by emergencies and disasters, including acts of terrorism involving weapons of mass destruction. The CDC Public Health Preparedness and Response for Bio-terrorism Program Announcement 99051 provides to the Division of Mental Health and Addiction through a sub-grant from the Indiana State Department of Health, specific funding to assist the State with developing and validating plans for Mental Health Services.

The Indiana Division of Mental Health and Addiction has developed the *All-Hazards Emergency State Plan* as a mental health and addiction emergency management standard for the State of Indiana. This All-Hazards Emergency State Plan has been developed in conjunction with the State of Indiana Comprehensive Emergency Management Plan.

The *All-Hazards Emergency State Plan* is a State-level management tool that will support the standard operating procedures of all participating community mental health centers and contracted Division of Mental Health and Addiction managed care providers. Written procedures will be developed by each of the 31 Community Mental Health Centers, which serve all 92 Indiana counties and will support the Counties Comprehensive Emergency Management Plans.

The community mental health centers or the designated mental health or addiction agency will be responsible to update and provide mental health response plans to the local emergency management agency director. These plans will focus on providing crisis counseling, mental health and addiction services for a community response before, during, and after an emergency or disaster, including acts of terrorism.

Plans to reallocate resources or expand funding to Community Based Services

This office has a history of moving state hospital funds to the community to increase community based funding. With the closure of one state hospital and the reduction of beds in the remaining hospitals we have reached a stage where further reductions are no longer possible. We continue a funding arrangement, called SOF agreement, in which mental health centers are paid a higher rate to remove people from the state hospitals that have a longer stay and maintain them in the community. This is designed to return patients with more than two years of hospitalization to the community. The SOF population has remained static for the past few years and they continue to provide more long term care than acute care. Generally, acute care is provided in the community by our contracted providers. The new state administration is examining the movement of some of the SOF's to local control with an emphasis on the need for more acute care. The plan to "localize" (privatize) one to three state hospitals by the end of state fiscal year 2006 is expected to have an impact on costs, use and operation of the state hospital

system in Indiana. Since the "localized" hospitals will be operated by communities rather than the state, there is a potential for improved community support in those areas where the state hospitals are located. However, until this plan is fully implemented, continued movement toward shifting services from state hospitals to the community is uncertain.

Mental Health Planning Council Issues/Recommendations

1. **Cultural and ethnic makeup of staff should be compared to the population served and cultural competence of staff.**
   - This will require a survey of providers. The DMHA Office of Critical Populations will be conducting this survey in the late summer, early fall of calendar year 2005. The data section has provided information on the racial and ethnic composition of state.

2. **Improve outreach to older adults through primary care**
   Older adults are less likely to seek out mental health services from specialty providers. Males age 85 and older have the highest rates of suicide. The mental health system needs to be more creative with outreach and service delivery for older adults with mental health challenges. Integration with primary care for early identification and treatment should occur. The planning council recommends that a portion of mental health block grant funding be identified to create and older adult institute for research, training, and education.

   - As noted under Criterion 1 above, DMHA has brought together most of the colleges and universities in the state for an Inter-College Council on Aging. Its purpose is to provide leadership and foster collaboration in gerontology research and education. Some of the members of this council are collaborating on submission of a federal grant to establish a Geriatric Education Center in Indiana that would be operated by a consortium of higher education institutions and would promote gerontology education for persons in the health professions.

3. **Be sure the 211 line has a good Mental Health link**
   According to information provided by a planning council member, the Indiana 2-1-1 line has some linkages and referral capacity. The planning council recommends that DMHA ensure that each 2-1-1 Information and Referral Center has extensive mental health resource information available to persons accessing the 2-1-1 system.

   - Indiana has established 8 regional Information and Referral Centers (covering 39 of the State's 92 counties) based on the 2-1-1 telephone line. Currently, four of these centers have web sites with on-line databases that can be accessed by persons needing services. These databases are used by the Information and Referral Centers when a call is received. Therefore, full access to the databases is available whether the person seeking information and/or referral calls 2-1-1 or does an on-line search. The state is currently working to link all the databases into one statewide database that will also be on-line. A review of the four existing on-line databases reveals substantial information within each regarding public

(and some private) mental health services as well as information about mental illness.

Information and Referral Centers involved in Indiana's 2-1-1 currently are funded privately through local United Ways, community foundations, other donors and sales of directories. Coverage for all 92 counties is expected to take several years and will be dependent upon availability of both private and public funding.

4. Licensing or Certification of Case Managers

The planning council membership is concerned about the variability of knowledge, skills, and expertise of persons hired by the public mental health system as case managers. The adult subcommittee recommends that DMHA institute a process to either certify or license case managers based on a standardized curriculum in order to ensure consistency of practice among the various providers.

- This is an area that has had some earlier discussions and there are similar discussions going on with the accreditation of other professionals. DMHA does not license or certify individuals. Indiana has a professional licensing office that is responsible for licensing of professionals based on legislation that authorizes the licensing of a profession. Currently, case managers are not included in the legislation, nor are substance abuse counselors although several attempts have been made to obtain legislation for the substance abuse counselors.

5. Treatment for victims of violence

- This office will survey providers to ascertain their levels of expertise. It is included in the HAP evaluation and it is used to generate the level of functioning score. But that is limited; the quality of the assessment would depend on the skills of the person doing the assessment interview. The survey of providers will ask what they have in the area of expertise in dealing with victims of violence or trauma.

6. Anti stigma efforts

- This needs further planning. Four DMHA staff and family members have participated in the "Caring for Every Child's Mental Health" campaign training. In SFY 2005 several Systems of Care staged events to honor May 4 as Children's Mental Health Day. This is to become an annual opportunity to educate the public about the importance of early intervention and that treatment works.

- This past legislative session saw the introduction of a bill that was drafted following two tragic deaths of law enforcement personnel at the hands of individuals identified as mentally ill and in possession of dangerous firearms. The original draft of the bill allowed police officers to remove weapons from anyone they thought was mentally ill and dangerous. This office and the state Mental Health Association (MHA) as well as many county MHA's opposed the language of the bill as it was stigmatizing and singled out a population as dangerous. Representatives of FSSA and advocacy organizations met in

legislative committee to discuss the language and offer alternative language. The resultant bill eliminated the language "dangerously mentally ill" and replaced it with "persons that are imminently dangerous".

There was tremendous public pressure to create legislation that would remove weapons from the "dangerously mentally ill" and the successful change in the language is seen as major event in avoiding stigmatizing language and a furthering of the public idea that all persons with a mental illness are dangerous.

7. **Public information effort**
   - This needs more planning. This office will be upgrading the website and several staff make public appearances during the year. As the state moves toward transformation of the mental health system, a major focus will be on health promotion which will include public information and educational materials.

8. **Increase WRAP and IMR**
   - This is a funding decision combined with a survey of attitudes in the field. DMHA will continue to support WRAP training through the Office of Consumer and Family Affairs and KEY Consumers. DMHA continues to evaluate funding possibilities for increasing IMR training.

9. **Get Office of Vocational Rehabilitation data on employment successes**
   - The Office of Vocational Rehabilitation has instituted an annual Report Card on Supported Employment providers. The data from the SE programs at mental health centers has been placed in a spreadsheet so that information on numerous variables can be easily compared. This spreadsheet was shared with the SE programs and provided to the planning council at the meeting on August 19, 2005. Quarterly reports will continue to be shared with the system and the council.

10. **Access to services**:
    Since there is no present measure of difficulty accessing services, the Consumer Council would like to see discussion on how the Division could measure the length of wait in the community system for services, just as it measures the length of wait for state hospital services. An example of how this could be done could be a single point of entry to apply for services, and then be referred to a provider. The Division would then know when someone first entered the door, and how long they had to wait to be served. If an agency cannot serve an individual, the agency should give the individual a reason in writing why they cannot serve them, and copy the Division. Also, the Consumer Council requests that the State Mental Health Planning Council be given a copy of the report on each CMHC's under-served or un-served persons after enrollment.

    - There is a question on the consumer survey regarding time to receive services and on accessibility. There is nothing in our present data set that would generate this measure. Waiting lists may exist at the provider level but creating a waiting list

database in order to measure activity statewide is problematic. This needs further discussion and consideration by the planning council.

11. Peer Support Services

The Consumer Council recommends that the Division begin to roll out Peer Support Services in Indiana in the same manner in which DMHA has done with ACT and Systems of Care. Peer Support Specialists should be included with each Supported Employment Program. Each year, DMHA can use some of the Block Grant funds (perhaps 10%) for services to be used in a special pool of consumers served by peer specialists working in a community mental health center. Or, DMHA can put out an RFP for communities to provide Consumer Run Organizations which will provide peer support services. There is now research evidence which substantiates that peer support services are evidence based practice, and should be supported by the Division.

- DMHA continues to be challenged by this recommendation. Currently some providers have hired Peer Support Specialists. DMHA will continue to work with the provider community to expand this practice. Consumer-Operated Services present a different challenge but is considered a priority for DMHA if funding can be identified. This needs further discussion.

10. Supported employment Results Based Funding: fund outcomes in increment incentives attached to the successful employment outcomes of consumers.
The Consumer Council recommends that the Division ask OVR to provide information on which providers are moving to results based funding. The Consumer Council requests that the Division then make this information available to consumers before they are enrolled in services, in order to choose the best provider.

- This is a direction that the Office of Vocational Rehabilitation (OVR) has taken on a limited basis with some pilot sites. The pilot tested the effectiveness of Results Based Funding. Payments were made based on achievement of milestones rather than payment on an hourly basis for job placement. The results indicated better outcomes with RBF than with hourly payments. The OVR contracts this year allow a provider to choose to use the RBF format for funding but do not mandate it. This is a funding decision that rests with OVR at this time. DMHA will ask OVR to provide us information on which providers are moving to results based funding.

11. Hearing impaired issues:
- **a. Need for staff personnel to acquire American sign language (ASL) skills**
- **b. Interpreters need to be certified nationally**
- **c. Providers need to be responsible for funding interpreters**
- **d. Provide staff training on how to utilize interpreters**
- **e. Utilization of new technology to provide services**

- DMHA will be working with a newly formed task force that will be examining the hearing impaired issues listed above. That task force will meet quarterly and will generate a report on their recommendations on the above issues. These recommendations will be shared with the planning council

SECTION III (ADULTS)

PERFORMANCE GOALS AND ACTION PLANS TO IMPROVE THE SERVICE SYSTEM

Criterion 1 (National Outcome Measures)

Goal A: Adults with SMI will receive appropriate and comprehensive community-based services.

Target: To maintain current levels of readmission to state psychiatric hospitals at 30 days and 180 days post discharge.

Population: Adults with a serious mental illness.

Criterion: Comprehensive, community-based mental health system.

Brief Name: ***Reduced Utilization of Psychiatric Inpatient Beds***

Indicator: The number of persons who are discharged from a state psychiatric hospital during the fiscal year who are re-admitted to a state psychiatric hospital at 180 days.

Measure: Numerator: Number of persons, aged 18+, who are readmitted to a State hospital within 180 days.
Denominator: None.

Source: The state hospitals maintain a database that is separate from the community services database. Information about admission and discharge is contained in that database for each individual served.

Special Issue: The state psychiatric hospitals are medium- to long-term care facilities. Therefore, the number of readmissions at 30 days is less than 5 persons and is an indicator used by the state psychiatric hospital system to monitor quality. The 180 days readmission also tends to be quite low but is being included here in order to comply with reporting National Outcome Measures.

Significance: This measure monitors the effectiveness of community services for persons who have been discharged from state psychiatric hospitals. As Indiana proceeds to localize (privatize) state psychiatric hospitals, monitoring both 30 day and 180 day readmissions will become an essential quality indicator for both community and hospital services.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Performance Indicator ***Reduced Utilization of Psyc. Inpt. Beds***	NA	6.5%	6.0%	6.0%	
Numerator	NA	29	35		---
Denominator	NA	447	582		---

Goal B: Evidence Based Practices will be implemented throughout the state within the community mental health system.

Targets: To increase the number of evidence-based practices provided by the community mental health system.

Population: Adults with a serious mental illness.

Criterion: Comprehensive, community-based mental health system.

Brief Name: ***Evidence-Based Practices Provided***

Indicator: The number of evidence-based practices being provided in the state.

Measure: Numerator: For each of the seven adult evidence-based practices (ACT, IDDT, IMR, Family Psycho-Education, Supported Housing, Supported Employment and Medication Algorithms), indicate (Yes-No) whether it is being provided.
Denominator: None

Source: DMHA supports the development of five of the evidence-based practices.

Special Issue: Implementation of evidence-based practices requires a significant investment of resources (both money and personnel). With the state experiencing budget deficits and needing to cut funding, there is a risk that continuing development of these practices may be slowed. The State is not supporting the development of Supported Housing or Medication Algorithms at this time.

Significance: This measure monitors the implementation of evidence-based practices by providers. Acceptance of and implementation of these practices following fidelity models is intended to improve the outcomes for adults with serious mental illness.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Performance Indicator ***EBP Provided (Y or N***)					
ACT	Y	Y	Y	Y	
IDDT	Y	Y	Y	Y	
IMR	Y	Y	Y	Y	
Family Psycho-Education	Y	Y	Y	Y	
Supported Employment	Y	Y	Y	Y	
Supported Housing	N	N	N	N	
Medication Algorithms	N	N	N	N	

Goal C: Consumers will have access to appropriate Evidence Based Practices.
Targets: To increase the number of consumers receiving evidence-based practices by 5% each year.
Population: Adults with a serious mental illness.
Criterion: Comprehensive, community-based mental health system.
Brief Name: ***Use of Evidence-Based Practices by Consumers***
Indicator: The number of adult consumers with SMI receiving evidence-based practices during the year.
Measure: Numerator: Number of adults with SMI, aged 18+, who are receiving any of the four evidence-based practices implemented within the State.
Denominator: None
Source: As of state fiscal year 2006, community mental health centers are required to enter information into the state database for each individual receiving ACT, Supported Employment, IDDT, and/or IMR.
Special Issue: The state database currently captures information about four evidence-based practices at the time of annual enrollment in the Hoosier Assurance Plan or at the six month reassessment. A consumer's participation in one or more of the practices may begin after enrollment or after the reassessment. Therefore, the counts are not considered truly representative of the numbers of persons actually involved in the evidence-based practices at any time during the fiscal year. Reassessments are not consistently reported by the providers. Family Psycho-education is provided by NAMI-Indiana through a contract with the state. However, these activities are not tied to specific consumers and, therefore, counts of consumers' families receiving this practice is not available.
Significance: This measure monitors the implementation of evidence-based practices by providers. Acceptance of and implementation of these practices following fidelity models is intended to improve the outcomes for adults with serious mental illness.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Performance Indicator ***Use of EBP by Consumers***	n/a	n/a	n/a	1,200	
Numerator	n/a	n/a	n/a	1,200	
Denominator	n/a	n/a	n/a		

Data is not available for previous years. Data will be available for next year's plan.

Goal D: Consumers will report positively about outcomes.
Target: To increase the number of consumers reporting positively about outcomes.
Population: Adults with a serious mental illness.
Criterion: Comprehensive, community-based mental health system.
Brief Name: ***Outcome***
Indicator: The number of consumers reporting positively about treatment outcomes.
Measure: Numerator: Number of positive responses reported in the outcome domain on the adult consumer survey.
Denominator: Total responses reported in the outcome domain on the adult consumer survey.
Source: Data is obtained through a telephone survey process using the 28-item MHSIP Adult Consumer Survey. Responses are entered into a database by the contractor which is submitted to DMHA for analysis.
Special Issue: This information is self-reported by consumers to interviewers over the phone. Any bias inherent in the methodology and any issues consumers may have regarding responses to the survey are unknown.
Significance: Consumer perception of the outcomes derived from their treatment services is the most sensitive domain on the adult consumer survey. Therefore, improvement in this domain will indicate general system improvement in the quality of services being provided.

Performance Indicator Table

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Performance Indicator: ***Outcome***		71.6%	66.2%	70%	
Numerator	---	1,193	1,205	---	---
Denominator	---	1,667	1,821	---	---

Criterion 1 (State Level Measures)

Goal E: Consumers will report positively about accessibility of services.
Target: To increase consumer's positive response regarding accessibility.
Population: Adults with a serious mental illness.
Criterion: Comprehensive, community-based mental health system.
Brief Name: ***Accessibility***
Indicator: Numerator: Number of positive responses by adults with SMI to the question "services are available at times that are good for me".
Denominator**:** Total number of responses by adults with SMI to the question, "services are available at times that are good for me".
Measure: Percentage of persons with serious mental illness that report positive responses "services are available at times that are good for me" on the MHSIP Consumer survey.
Source: Data is obtained through a telephone survey process using the 28-item MHSIP Adult Consumer Survey. Responses are entered into a database by the contractor which is submitted to DMHA for analysis.
Special Issue: This information is self-reported by consumers to interviewers over the phone. Any bias inherent in the methodology and any issues consumers may have regarding responses to the survey are unknown.
Significance: Accessibility of services at times that are convenient to the consumer can improve consumer participation in and compliance with his/her treatment plan.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Performance Indicator: ***Accessibility***		81.2%	77.3%	77.3%	
Numerator	---	1,443	1,516	---	---
Denominator	---	1,778	1,961	---	---

Goal F: To provide case management services for all adults receiving services through the public mental health system who are in need of these services.
Target: To increase by two percent the percent of individuals with a serious mental illness who receive case management.
Population: Adults with a serious mental illness.
Criterion: Comprehensive, community-based mental health system.
Brief Name: ***Case management***.
Indicator: Percentage of adults with serious mental illness who receive case management services among those who receive public mental health services.
Measure: Numerator: The number of adult recipients with a serious mental illness who are receiving case management services during the fiscal year.

Denominator: The number of adults who receive public mental health services during the fiscal year.

Source: Community Services Data System (CSDS), the Indiana community services database. Encounter information using procedure codes is entered into the database by the providers of service.

Special Issue: None.

Significance: Assuring access to case management services for persons with a serious mental illness is a primary goal of the mental health block grant legislation.

Performance Indictor Table

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Performance Indicator: ***Case Management***	58%	58%	58%	60%	
Numerator	24,290	27,747	---	---	---
Denominator	41,879	48,037	---	---	---

Goal G: Consumers will report positively about the quality and appropriateness of services.

Target: To increase consumer's positive response regarding quality and appropriateness of services.

Population: Adults with a serious mental illness.

Criterion: Comprehensive, community-based mental health system.

Brief Name: ***Quality of Care***

Indicator: Numerator: Number of positive responses by adults with SMI to the questions in the Quality/Appropriateness domains.
Denominator**:** Total number of responses by adults with SMI to the questions in the Quality/Appropriateness domains.

Measure: The percentages of persons with a serious mental illness have positive responses to the Quality/Appropriateness domains on the MHSIP Consumer survey.

Source: Data is obtained through a telephone survey process using the 28-item MHSIP Adult Consumer Survey. Responses are entered into a database by the contractor which is submitted to DMHA for analysis.

Special Issue: This information is self-reported by consumers to interviewers over the phone. Any bias inherent in the methodology and any issues consumers may have regarding responses to the survey are unknown.

Significance: Meeting the treatment needs of consumers can improve consumer participation in and compliance with his/her treatment plan.

Performance Indicator Table

	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Performance Indicator: ***Quality of Care***		83.7%	77.3%	80%	
Numerator	---	1,470	1,593		
Denominator	---	1,756	1,930		

Goal H: Consumers will report positively about their general satisfaction with services.
Target: To increase consumer's positive response regarding general satisfaction with services.
Population: Adults with a serious mental illness.
Criterion: Comprehensive, community-based mental health system.
Brief Name: ***Satisfaction***
Indicator: Numerator: Number of positive responses by adults with SMI to the questions related to general satisfaction.
Denominator**:** Total number of responses by adults with SMI to the question related to general satisfaction.
Measure: The percentage of persons with serious mental illness that report positively on the general satisfaction with services items on the MHSIP Consumer survey.
Source: Data is obtained through a telephone survey process using the 28-item MHSIP Adult Consumer Survey. Responses are entered into a database by the contractor which is submitted to DMHA for analysis.
Special Issue: This information is self-reported by consumers to interviewers over the phone. Any bias inherent in the methodology and any issues consumers may have regarding responses to the survey are unknown.
Significance: Accessibility of services at times that are convenient to the consumer can improve consumer participation in and compliance with his/her treatment plan.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Performance Indicator: ***Satisfaction***		81.5%	79.7%	80%	
Numerator	---	1,457	1,566	---	---
Denominator	---	1,788	1,965	---	---

Goal I: To improve the employment status for adults with SMI receiving services through the public mental health system.

Target: To increase by two percent the percentage of adults with a serious mental illness who are employed from one year to the next.

Population: Adults with a serious mental illness.

Criterion: Comprehensive, community-based mental health system.

Brief Name: ***Percentage Employed***.

Indicator: Percentage of adults with serious mental illness receiving services through the community mental health system who report being employed.

Measure: Numerator: The number of adult consumers with a serious mental illness who are employed during the current fiscal year.
Denominator: The number of adult consumers with a serious mental illness who are enrolled during the current fiscal year.

Source: Community Services Data System (CSDS), the Indiana community services database. Information about employment status of each consumer is entered into the database by the providers of service at annual enrollment and reassessment.

Special Issue: The state database currently captures information about employment status at the time of annual enrollment in the Hoosier Assurance Plan or at the six month reassessment. A consumer's employment status may change after enrollment or after the reassessment.

Significance: Consumers report that being employed is one of their major goals. However, employment statistics reveal significantly lower rates of employment for these consumers than the rates of employment for the general population. Therefore, improving the employment rates for consumers should help promote their recovery.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Performance Indicator ***Percentage Employed***	21%	21%	21%	23%	
Numerator	10,261	10,536	11,289		
Denominator	48,014	50,542	52,707		

Goal J: To improve the independent living arrangement for older adults with SMI receiving services through the public mental health system.

Target: To increase by two percent the percentage of older adults (aged 65+) with a serious mental illness who are living independently from one year to the next.

Population: Adults with a serious mental illness.

Criterion: Comprehensive, community-based mental health system.

Brief Name: ***Percentage Older Adults Living Independently***.

Indicator: Percentage of adults aged 65+ with serious mental illness receiving services through the community mental health system who report living in a home or apartment.

Measure: Numerator: The number of adult consumers aged 65+ with a serious mental illness who are living in a home or apartment during the current fiscal year.
Denominator: The number of adult consumers aged 65+ with a serious mental illness who are enrolled during the current fiscal year.

Source: Community Services Data System (CSDS), the Indiana community services database. Enrollment and reassessment information related to living arrangement is entered into the database by the providers of service.

Special Issue: The state database currently captures information about living arrangement at the time of annual enrollment in the Hoosier Assurance Plan or at the six month reassessment. A consumer's living arrangement may change after enrollment or after the reassessment.

Significance: Older adults desire to retain their independence as long as possible. Therefore, living independently, rather than in some type of congregate setting, is a way to preserve this independence.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Performance Indicator: ***Percentage of Older Adults Living Independently***	44%	46%	48%	50%	
Numerator	1,514	1,579	1,735	---	---
Denominator	3,439	3,466	3,603	---	---

Criterion 2 (National Outcome Measures)

Goal A: Persons in need of publicly supported mental health services will have access to services.

Target: To maintain the current level of access to services.

Population: Adults with a serious mental illness.

Criterion: Mental Health System Data Epidemiology.

Brief Name: ***Access***

Indicator: The number of unduplicated adults with SMI that are enrolled in mental health services during the fiscal year.

Measure: Numerator: The number of persons enrolled in the state database with agreement types of SMI and Co-Occurring Disorder.
Denominator: None

Source: Community Services Data System (CSDS), the Indiana community services database. Enrollment information is entered into the database by the providers of service.

Special Issue: Enrollment in the state database is the method used by the state to fund the providers. Each enrollment triggers a funding payment up to an allocation amount. After the allocation amount is paid, the providers may or may not continue to enter enrollments into the database. Therefore, the providers may be under-reporting actual numbers of persons served. Any cuts in funding for the community mental health system are likely to result in fewer persons receiving services.

Significance: Assuring access to services is one of the major responsibilities of the state mental health authority.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year Performance Indicator: ***Access***	FY 2003 Actual	FY 2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 Attain
Number Enrolled	48,014	50,542	52,707	52,707	
18 - 20	2,610	2,756	2,786	2,786	
21 - 64	42,088	44,467	46,460	46,460	
65 – 74	1,784	1,821	1,886	1,886	
75 +	1,532	1,498	1,575	1,575	
Gender	48,014	50,542	52,707	52,707	
Male	18,640	19,570	20,530	20,530	
Female	29,374	30,972	32,177	32,177	
Race/Ethnicity	48,014	50,542	52,707	52,707	
American Indiana or Alaska Native	155	195	221	221	
Asian	108	117	120	120	
Black or African-American	5,592	5,799	6,078	6,078	
Native Hawaiian or other Pacific Islander	28	17	23	23	
White	41,108	43,153	45,020	45,020	
More than one Race	186	206	267	267	
Race Not Available	927	1,055	978	978	
Hispanic	1,872	1,482	1,492	1,492	

Criterion 2 (State Level Measures)

Goal B: Persons in need of publicly supported mental health services will receive services.

Target: To maintain the current penetration rate of persons estimated to be in need of Hoosier Assurance Plan services.

Population: Adults with a serious mental illness.
Criterion: Mental Health System Data Epidemiology.
Brief Name: ***Penetration Rates***.
Indicator: The percentage of persons eligible for Hoosier Assurance Plan services who receive the services.
Measure: Numerator: The number of persons with SMI and Co-Occurring Disorder who receive publicly funded services under the Hoosier Assurance Plan.
Denominator: The number of persons with incomes at or below 200% of the federal poverty level who are estimated to be in need of services.
Source: Community Services Data System (CSDS), the Indiana community services database. Enrollment information is entered into the database by the providers of service. Prevalence Reports produced by DMHA.
Special Issue: Enrollment in the state database is the method used by the state to fund the providers. Each enrollment triggers a funding payment up to an allocation amount. After the allocation amount is paid, the providers may or may not continue to enter enrollments into the database. Therefore, the providers may be under-reporting actual numbers of persons served. Any cuts in funding for the community mental health system are likely to result in fewer persons receiving services.
Significance: Assuring access to services is one of the major responsibilities of the state mental health authority.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Performance Indicator: ***Penetration Rates***	72.6%	76%	80%	80%	
Numerator	48,037	50,542	52,618	---	---
Denominator	66,129	66,129	66,129	---	---

Criterion 4 (State Level Measures)

Goal A: Persons who are homeless and in need of publicly supported mental health services will have access to services.
Target: To maintain the current level of access to services.
Population: Adults with a serious mental illness.
Criterion: Targeted Services to Homeless Populations.
Brief Name: ***Homeless Access***
Indicator: The number of unduplicated adults with SMI who are homeless that are enrolled in mental health services during the fiscal year.
Measure: Numerator: The number of persons enrolled in the state database with agreement types of SMI and Co-Occurring Disorder who are reported as homeless.
Denominator: None

Source: Community Services Data System (CSDS), the Indiana community services database. Enrollment information is entered into the database by the providers of service.

Special Issue: Enrollment in the state database is the method used by the state to fund the providers. Each enrollment triggers a funding payment up to an allocation amount. After the allocation amount is paid, the providers may or may not continue to enter enrollments into the database. Therefore, the providers may be under-reporting actual numbers of persons served. Any cuts in funding for the community mental health system are likely to result in fewer persons receiving services.

Significance: Assuring access to services is one of the major responsibilities of the state mental health authority.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Estimated	FY 2006 Target	FY 2006 % attain
Performance Indicator: ***Homeless Access***	2,500	2,780	2,800	2,800	
Numerator	2,500	2,780	2,800	2,800	---
Denominator	---	---	---	---	---

Goal B: Persons who live in rural areas of the state and in need of publicly supported mental health services will have access to services.

Target: To maintain the current level of access to services.

Population: Adults with a serious mental illness.

Criterion: Targeted Services to Rural Populations.

Brief Name: ***Rural Access***

Indicator: The number of unduplicated adults with SMI who are living in rural areas of the state and are enrolled in mental health services during the fiscal year.

Measure: Numerator: The number of persons enrolled in the state database with agreement types of SMI and Co-Occurring Disorder who are living in rural areas of the state.
Denominator: None

Source: Community Services Data System (CSDS), the Indiana community services database. Enrollment information is entered into the database by the providers of service.

Special Issue: Over 68 % of Indiana's counties are rural with slightly over 72% of the population aged 18 and over living in urban counties. Of the adults with serious mental illness served by the public mental health system, approximately 69% live in urban counties and 31% live in rural counties.

Significance: Assuring access to services is one of the major responsibilities of the state mental health authority.

Performance Indictor Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Estimated	FY 2006 Target	FY 2006 % attain
Performance Indicator: ***Rural Access***	10,100	15,021	16,313	16,400	
Numerator	10,100	15,021	16,313	16,400	---
Denominator	---	---	---	---	---

Criterion 5 (State Level Measures)

Goal A: Public funding for the community mental health system will remain stable or increase.

Target: To stay within 10% of the state fiscal year 2005 expenditure of DMHA funds for the purchase of services for adults with serious mental illness.

Population: Adults with a serious mental illness.

Criterion: Management Systems.

Brief Name: ***DMHA Funds***

Indicator: The amount of DMHA funds expended for adults with serious mental illness.

Measure: Numerator: The amount of funds allocated for services for individuals with agreement types of SMI and Co-Occurring Disorder.
Denominator: None

Source: Community Services Data System (CSDS), the Indiana community services database. Enrollment information is entered into the database by the providers of service.

Special Issue: Enrollment in the state database is the method used by the state to fund the providers. Each enrollment triggers a funding payment up to an allocation amount. After the allocation amount is paid, the providers may or may not continue to enter enrollments into the database. Therefore, the providers may be under-reporting actual numbers of persons served. Any cuts in funding for the community mental health system are likely to result in fewer persons receiving services.

Significance: Assuring access to services is one of the major responsibilities of the state mental health authority.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Performance Indicator: ***DMHA Funds*** (in 000's)	82,500	82,500	82,500	82,500	
Numerator	82,500	82,500	82,500	82,500	---
Denominator					---

SECTION II. (CHILD AND ADOLESCENT)

IDENTIFICATION AND ANALYSIS OF THE SERVICE SYSTEMS STRENGTHS, NEEDS, AND PRIORITIES

Criterion I: Comprehensive Community-based mental health services systems

Publicly funded children's mental health services in Indiana are financed through five separate state agencies, each with distinct eligibility requirements. Medicaid is the largest purchaser of services through Hoosier Healthwise, and the SCHIPS program. The 1915(c) Home and Community-based waiver for children with serious emotional disturbance (SED Waiver) assures the option of community care for a limited number of children/youth that are eligible for State Psychiatric Hospital admission. The Department of Child Services funds services for CHINS (children in need of services) through each county. Historically, local DCS expenditures were governed largely by the local county judiciary. With the election of a new state administration in 2004, child welfare expenditures are now subject to approval by the Director of the Department of Child Services. The Division of Exceptional Learners of the Department of Education (DEL/DOE) provides funding for intensive services to youth who cannot be educated using existing local resources. National statistics project that 4% of the school population will be classified as emotionally disturbed; Indiana reports 1% as emotionally disturbed. Youth remanded to the Department of Correction (DOC) are provided with some in-house mental health and addiction treatment, such as the Sex Offender Treatment program at one facility. Youth who require specialized treatment are sometimes placed in residential care through correction funding. The Division of Mental Health and Addiction (DMHA) funds community-based child services through a network of providers. About 10% of the DMHA budget is allocated for community based programs targeting children with serious emotional disturbance (SED) at or below 200% of poverty.

Children are served by the Division of Mental Health and Addiction through one of 31 **Community Mental Health Centers** or other contracted care providers, with multiple locations thought the state. Children are assessed with the Hoosier Assurance Plan Instrument for Children (HAPI-C), with income eligibility established on a family income at or below 200% of the Federal Poverty Level (FPL). The goal of the Hoosier Assurance Plan is to assure community-based living. The HAPI-C measures the child's level of functioning and self-management skills relative to the child's appropriate development. The Hoosier Assurance Plan is designed to equalize the availability and quality of community-based mental health and addiction services across the state for those most in need with an array of mental health services. Level and intensity of services are determined though the development of an individualized treatment plan.

Each CMHC reaches a primary service area to assure adequate statewide coverage. The Community Mental Health Centers are gatekeepers for the state hospital system, fostering collaboration between the CMHC and the hospital. With the implementation of the SED

Waiver in 2003, a Level of Care application is required for every potential child/youth admission to the state hospitals. The application process requires an assessment of the adequacy of attempts to provide community care prior to hospitalization. Gate keeping responsibilities include monitoring of the hospital stay, case management duties, discharge planning and follow-along services. Face to face quarterly meetings with the child/youth and family are required.

Community Mental Health Centers and other providers are required to provide a range of services for children. Indiana Administrative Code defines the populations to be served, the continuum of care, and minimum standards for the provision of services. Minimum standards for the following components of a continuum of care are defined in state law as: case management, outpatient services, medication evaluation and monitoring, and family support.

The **continuum of care** assures adequate services for youth with substance abuse and /or co-occurring mental health issues. Services range from substance abuse education to intensive out patient programs. DMHA provides leadership in moving toward evidence-based, integrated treatment for youth with mental health and substance use through facilitation of several statewide presentations by nationally-recognized practitioners/ researchers. The first "Women and Youth Reaching Recovery" conference was held in April, 2005. The two day event brought together youth and women in recovery, providers and practitioners. The event was so successful that a 2006 conference is being planned.

Working collaboratively with the **Substance Abuse Prevention and Treatment** (SAPT) block grant, training for providers on integrated treatment for adolescents has been provided. With the recently awarded Strategic Prevention Framework grant by SAMHSA, we will work to create a community-based approach to substance use prevention and mental health promotion cutting across existing programs and systems. An application has been made for a Cooperative Agreement for State-Sponsored Youth Suicide Prevention and Early Intervention program for the Indiana Youth Suicide Prevention Project. The project is a collaboration of DMHA, Indiana Suicide Prevention Coalition and the Behavioral Health & Family Studies Institute at Indiana University-Purdue University at Fort Wayne. The Indiana Youth Suicide Prevention Technical Assistance Centers would be created to provide resources for youth suicide prevention planning and programming across the state.

Indiana continues to move forward in supporting evidence-based thinking with the development of a DMHA task force that will identify ways to assist providers in offering treatment with positive outcomes. The Technical Assistance Center for Systems of Care and Evidence-Based Practices for Children and their Families will assist providers in articulating their practice models and associated fidelity indicators. As fidelity and outcome data are collected on a wide variety of services delivered, effective models of care will quickly emerge. These models will be shared and implemented in other communities.

Three **state hospital** units serve children. The new Secretary of the Indiana Family and Social Services Administration (FSSA) has initiated a process to localize three of the six state hospitals, which will eventually remove them from the state operation. It is estimated this process will take at least one year to effectuate. State hospital capacity for children is 90 beds. One of the units serves adolescent males, another serves children 5 through 12 and the third serves all youth. The facility serving younger children seldom reaches capacity. Each year, for the past three years, the number of children served has declined. During 2005, six children were discharged to community-based care through the Home and Community-based waiver.

Since the mid-1990's **children's Systems of Care (SOCs**) have developed throughout the state to serve children with serious emotional disturbances. Some were initially supported by state funds and others solely through community efforts. Beginning in 2000, DMHA offered seed funding for newly developing SOCs. At the beginning of SFY 2006 there are 36 SOCs, including 2 federally funded sites. Two-thirds of Indiana counties are served by SOCs. During SFY 2005, 904 children were enrolled in SOCs, which equates to approximately 3.06% of all children served in the community public mental health system during 2005. Three Indiana communities have submitted proposals to SAMHSA/CMHS to fund their sites. All of the applications are promising. One will serve the Old Amish Order population (the second largest concentration of Amish in the U.S.); another proposes to reach 18 rural, impoverished counties, and one will combine urban/rural communities.

Indiana's SOCs are nurtured by the state-funded **Technical Assistance Center for Systems of Care and Evidence-Based Practices for Children and Families (TAC**). The TAC offers ongoing, onsite coaching and consultation for SOCs, as well as regional trainings, an annual conference, website, list serve and newsletters. It conducts developmental assessments for each SOC that can be used in planning and for sustainability analysis. Founded in 2003, the TAC also provides consultation to communities who are considering the development of a System of Care.

Matching funds for the **1915(c) waiver** are braided from Department of Correction (DOC), Department of Education (DOE), State Medicaid and DMHA. During the first full year of the waiver, thirty-eight applications have been made; twenty-nine children and their families are currently being served. Six of those children were discharged from State Hospitals into their community's System of Care. Four children have graduated from the waiver. Fifty-five children will be served through the waiver in 2006.

Consumer choice for SED children and their families has been expanded with the approval of the SED waiver. The menu of possible services includes:

- *Case management/wraparound facilitation*: assessment of the child's and family's strengths and needs to determine services needed from the community based waiver and non-waiver services. The community-based plan identifies specific goals, objectives, responsibilities timeliness, outcomes, performance measures, and costs. It emphasizes collaboration and coordination among family, caretakers, service providers, educators and other community resources.

- *Family support and training*: assisting and coaching the family to increase their knowledge and awareness of child's needs, the process of interpreting choices offered by service providers, explanations and interpretations of polices, procedures, regulations that impact the child living in the community, and behavioral management training.
- *Independent living skills*: assist children and adolescents in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.
- *Respite care*: short term and temporary direct care and supervision for youth. The primary purpose is to provide relief for families/caretakers of a child with a severe emotional disturbance so that the caretakers can participate in activities that may not be accessible or acceptable for the child.

The service needs of Indiana's children and youth are addressed by a multiplicity of programs and community-based entities. The **Indiana Department of Education** provides an array of mental health services to students with an emotional disability through the Division of Special Learners and the IDEIA program. DOE makes available to school systems funding for children who cannot be educated within the system. These children are sent to residential treatment centers. Increasing numbers of school districts offer wraparound services for their students.

Children's services supported by the **Department of Child Services** and the **Division of Family Resources** include: child protection and placement, First Steps Early Intervention (part C), Title IV-E waiver program, TANF, Independent Living, Safe Housing-Runaway program, Healthy Families, alternative living, preventative health care, child care services, parenting skills, and licensing of child placing agencies.

The **Indiana State Department of Health (ISDH**) collaborates with DMHA in crafting the mental health component of the state's children's health plan. They offer a program for children with chronic health conditions and links with First Steps (part C) through the Children's Special Health Care Program. DMHA has served as a core partner with ISDH in its planning grant, to be awarded by Division of Maternal and Child Health, for Early Childhood Comprehensive Community-based Systems. The grant will support training for foster parents and other care providers about early childhood mental health needs, as well as assist in data evaluation. This represents a significant collaboration between ISDH and DMHA, because it is in support of the DMHA-initiated early identification, assessment and treatment initiative for children entering the child welfare system.

The **Office of Medicaid Policy and Planning** supports primary medical and mental health services and dental services for children. They have been successful in securing the 1915(c) Home and Community-based Waiver for children enabling SED youth to have the option of community-based care rather than hospitalization.

The Division supports **access to psychiatric liaison consultation to hospitalized children** and their families who are being treated for acute and serious medical problems at the Indiana University School of Medicine's children's facility, Riley Hospital. This

service makes available a level of consultation often not accessible in the family's home community. During 2005, 430 hours of consultation liaison services were provided.

During 2005, the Division's **Office of Consumer and Family Affairs** (OCFA) offered services through participation in statewide Systems of Care meetings, consultation with newly forming family support groups and conducting many community presentations. The OCFA has trained 106 consumers in advocacy and leadership skills. With funding from the CMHS, under the Olmstead grant, the OCFA partnered with the KEY Consumer organization to bring training to local communities. A parent of several children with SED and a youth transitioning to adult services will be trained to make these skill-building trainings available to youth and family members. OCFA has provided WRAP (Wellness Recovery Action Plan) training at Community Mental Health Centers and to a SOC consortium. It is anticipated that requests for this training for families of SED children will increase during 2006.

Under state contract the **Indiana Federation for Families for Children's Mental Health** (IFOFCMH) presented the first statewide conference, "Celebrating Families", with 102 persons in attendance. The inaugural conference gave an opportunity to newly forming family support organizations, and Systems of Care family participants, to learn from experienced organizations. This conference gave several families their first opportunity to attend a conference and to stay in a hotel. During SFY 2005, the Federation conducted 36 consultations to individuals/groups who are interested in forming family support groups. They also developed a family website, and have published four newsletters.

The upcoming satisfaction with services annual report will provide information received from a telephone survey of family members of children. The survey instrument, the Youth Services Survey for Families, asks questions about access, participation, rights and satisfaction with services. The report offers youth and their families' information about mental health services that can help them determine the services they may select. This will be the third publication of the results of this survey.

Indiana is **transforming our mental health system.** The Governor and his Administration are committed to building a mental health system that is compassionate, consistent, proactive and accountable.

DMHA is represented on the Governor's Interagency Coordinating Council for Infants and Toddlers (First Steps), the Head Start State Panel and Transition Planning Task Force of the Office of Vocational Rehabilitation and Department of Education. DMHA contributes a monthly newsletter column for all Head Start providers. DMHA staff is an active participant with the Indiana Council of Community Mental Health Centers Child and Adolescent Consortium. Staff serves as Principal Investigator for the Circle Around Families Federal grant site and on the Executive Committee of the Dawn Project, both of which are graduating Federal grant sites. DMHA also serves on the Department of Child Services Endangered Child Protocol Development Task Force and the Children's Social, Emotional and Behavioral Health Plan group. Additionally, the DMHA children's team

has provided leadership to the Cross-System Team as they developed plans for the Early Intervention initiative, and the subsequent ad hoc Assessment Committee, which has recommended an assessment instrument for use across systems.

Strengths

- Community Mental Health Centers and other **providers offer a range of services** for children. Indiana Administrative code defines the population to be served, the continuum of care and sets service standards. The continuum includes case management, outpatient services, medication evaluation and monitoring, and family support. Contracts with providers assure Indiana children have access to mental health and addiction services anywhere in the state.
- With the development of Systems of Care, over 75% of the state's youth population lives in areas served by a System of Care. There has been a **25% increase in number of children served in Systems of Care** from the previous year.
- The **1915(c) waiver** offers community-based care to children who would otherwise be admitted to a state hospital. During the year 29 children and their families were served, four graduated. Funding for the waiver has been braided from Department of Corrections, Office of Medicaid Policy and Planning, Department of Education and DMHA. Indiana's commitment to keeping children in their communities can be tracked with reduction of admissions to state hospitals during the past two years.
- Strong cross-systems collaborations have resulted in the **Early Identification and Intervention** statewide initiative. Any child being placed in substitute care or who become wards of the state through the child welfare system must be screened to determine if there is a potential mental health issue. If the screen is positive, the child is referred for an assessment. Should the assessment establish a need for treatment, a treatment plan is developed. During the first six months, 75% of children entering the system were screened. Of those children, 35% were flagged as needing immediate intervention. This initiative is an important accomplishment because it was launched in a short timeframe, it resulted in the first-ever cross-agency data sharing (Child Services, Mental Health and Medicaid) and is creating an early childhood mental health training program for foster parents.
- Significant opportunities for improvement of children's mental health have developed from the new administration. The Indiana Family and Social Services Administration no longer has responsibility for child welfare services. The Department of Child Services has been established as a cabinet level agency by the Governor. A product of this change is a legislated mandate to **develop a children's social, emotional and behavior plan** by June 2006. The plan will be developed by the Department of Education, Department of Child Services, Department of Corrections, State Department of Health, Office of Medicaid Policy and Planning and Division of Mental Health.

Challenges

- We continue to serve more children, despite no increase in funding. This year we served 10% more children than in the previous year. The year prior, we had a 9% increase.

- Providers are awarded an allocation when a child is enrolled. Most providers continue to enroll children long after their DMHA award has been drawn. In FY 2005, 76% of children served were covered by Medicaid at the time of enrollment, 19% had some other form of health insurance, and 5% were uninsured. Since private insurance coverage tends to be very limited, there exists a significant gap in coverage which providers must either fund or not offer.
- The community mental health centers are struggling to balance increasing demand with limited resources. State funds allocated to the centers are first used as state match for the federal portion of Medicaid. As more children enter the system with Medicaid funding, fewer dollars are available for services to non-Medicaid and/or indigent children.
- A recently conducted actuarial indicates providers are serving more children with high to moderate functioning, as opposed to those who are low functioning.

Unmet needs/gaps

- Based on estimated prevalence rates, for the designated DMHA child population (at or below 200% of federal poverty level), up to 10,000 youth may not be receiving services. (The actual number not receiving services is unknown as many children do receive some level of service from primary care and other providers not in the public mental health system.)
- With implementation of the Home and Community-based waiver, we have been challenged to develop the necessary community supports to fully support the waiver.
- There are an insufficient number of mental health professionals who are trained to assess and treat younger children. Indiana does not have a sufficient number of child psychiatrists. Few mental health professionals are trained to concurrently address both mental health and substance use disorders. Higher education has been slow in addressing these issues.
- There are few acute care resources for children in crisis. Often the juvenile justice system is inappropriately used as a resource. Indiana does not have adequate respite resources for families living with a SED youth/child.

Criterion 2
Mental Health System Data Epidemiology

State Definition of SED

In Indiana the Division of Mental Health and Addiction considers children to encompass birth through 17 years of age. The implemented definition of SED is as follows:

The child has a mental illness diagnosis under DSM IV.
The child experiences significant functional impairments in at least one of the following areas:
Activities of daily living,
Interpersonal functioning,
Concentration, persistence and pace,
Adaptation to change

The duration of the mental illness has been, or is expected to be, in excess of twelve (12) months. However, children who have experienced a situational trauma, and who are receiving services in two or more community agencies, do not have to meet the duration requirement of this clause.

This definition closely parallels the federal definition of serious emotional disturbance and for purposes of reporting data regarding persons served in Indiana is considered equivalent.

Description of Estimation Methodology

The Division of Mental Health and Addiction uses two methodologies for estimating the prevalence of children aged 9 through 17 with Serious Emotional Disturbance in Indiana. The first method is calculated using the Center for Mental Health Services methodology. The second method is based on the eligibility requirements for the Hoosier Assurance Plan, which established eligibility at or below 200% of the federal poverty level. DMHA does not attempt to estimate the prevalence of children with SED for those younger than age 9 since there are no national studies that have included these very young children. Children aged birth through age 8 comprise 29% of the children receiving public mental health services in Indiana. Both calculations are provided in Section III.

Strengths/weaknesses

- The Hoosier Assurance Plan (HAP) directs public funding to those individuals in greatest need of mental health services. HAP is designed to equalize the availability and quality of community-based mental health and addiction treatment with an individualized array of services.
- During state funding year 2005, 67% of children aged 9-17 and estimated to be in need of and eligible for state-funded services (living in families earning less than 200% of the Federal poverty level), received public mental health services. Given diminished funding, this is a strength because it demonstrates that providers are serving children for whom they do not receive DMHA reimbursement. It is also a challenge, because there are more children needing services who do not receive them.
- The Mercer Government Human Series Consulting group concluded during a 2004 study that the HAPI-C (children's assessment tool) is consistently the most powerful risk predictor.

Criterion 3:
Children's Services

The Family and Social Services Administration's Division of Mental Health and Addiction (DMHA**)** is the state mental health authority. The Division advocates for the needs of persons in the target populations; establishes policy for funding and evaluation of community-based mental health and addiction treatment providers; establishes policy for and funding of a system of substance abuse prevention projects; establishes rules for

the regulation of mental health providers; and currently operates a system of state psychiatric hospitals.

During FY 2006 DMHA will allocate block grant dollars in accordance with requirements identified in Section 1911. Stipulations are written in the contracts of each certified and approved provider of SED services.

The entire state is identified as the geographic region for block grant coverage. The identified service areas of the 25 providers of children's services cover all of Indiana's 92 counties.

Substance Abuse Services

Approved providers for SED children are required to offer substance abuse counseling and treatment for children dually diagnosed with SED and substance use and addiction. They must also assess the need for mental health services, and if appropriate, make referral for such services. In concert with various provider groups, we are exploring best practices in integrating substance abuse/mental health services for adolescents. SAMHSA has presented compelling research about more effective ways to treat dually diagnosed youth, which have been disseminated through several conference presentations.

Comprehensive Community Based Care Development

The Division partners with many state and local agencies that serve children. It encourages providers with whom it contracts to expand mental health services to children and families who are referred from child welfare, the schools, the juvenile courts and others. State mental health legislation that identifies continuum of care services puts a focus on services being provided in the community.

The **Office of Medicaid Planning and Policy (OMPP**) support primary medical, mental health services and dental services for eligible children. Through OMPP, DMHA has been successful in securing a 1915(c) Home and Community-based Waiver for children enabling SED youth to have the option of community-based care rather than hospitalization.

The **Indiana Department of Education**, through its Division of Exceptional Learners, has committed financial support of the waiver for a limited number of children under its auspices. The Division of Special Learners is a co-convener of the Children's Social, Emotional and Behavioral Health Planning team. Through their participation in the Cross-Systems Team they have assisted in the planning and implementation of the Early Identification and Intervention initiative (referred to as the child welfare screening).They also partner with DMHA in work with the Indiana Bar Association to address juvenile justice/mental health issues.

The **Indiana Department of Child Services (DCS**), in addition to provision of programs mentioned in Criteria I, is the pivotal participant in the child welfare screening, assessment and treatment initiative. Beginning in January, 2005 all 92 counties

implemented a mental health screen for certain children entering the child welfare system. Each county developed a plan with their local Community Mental Health Centers for follow-up assessment and treatment.

Juvenile Justice services are carried out through separate systems: county juvenile courts, county probation offices, 25 county-based detention centers and the Department of Correction, for incarcerated youth. There is no single Juvenile Justice authority in Indiana. The **Department of Correction (DOC**) offers mental health programs, as well as community reintegration pilots. Juvenile Courts and probation departments provide diversion and treatment programs. Detention Centers contract with mental health service providers. DMHA has developed partnerships with several entities with juvenile justice responsibilities. DOC has provided fiscal support for the state match for the HCB 1915(c) waiver. They are partners on the Cross-System Team. The **Indiana Criminal Justice Institute** (ICJI) provides funding for the Screening Coordinator position, as well as funding for evaluation and data collection.

Strengths/weaknesses: Indiana has been very successful in forging productive partnerships among child serving agencies. We have been able to "get people to the table" through common values and visions. These significant initiatives are the result of several years' work. The state's goal to bring all child serving entities together in a consolidated "forum" that frames a comprehensive plan for our children has been addressed through Senate Enrolled Act 529, which calls for the formation of the Children's Social, Emotional and Behavioral health plan. A full report is required to be filed with the legislature in June, 2006.

Challenges: Our collaborators and partners are limited in the financial resources they can bring to the table. There is a need for Federal leadership to endorse and support serious cross-systems endeavors. Implementation of the HCBS waiver has required considerable effort and focus. Although we have enrolled children, we need a sufficient number of providers for the specialized waiver services.

Criterion 4
Services to Rural and Homeless Populations

Description of Homeless Population and Available Services
The definition of homelessness is persons who have no fixed address. They may live on the street, in a car or an abandoned structure. They may also be living in a shelter, living with family or friends under crowded or stressful conditions, living in deteriorated and unsafe housing often without utilities, or involved in support programs without which there would be a high risk of homelessness.

Local mental health providers offer outreach services to children and families who are homeless. Services include crisis intervention, involvement with the homeless shelters in the community and supervised group living residential arrangements.

Definition of Rural and Description of Service Barriers
The Indiana definition of rural is "any county with a population of 100 persons per square mile or less." Sixty-three (63) of Indiana's 92 counties meet the definition of rural. The estimated 2005 census shows a total state population of 6,273,130 persons. There are 2,128,463 persons (34%) who live in rural counties.

The Division contracts with 25 providers for services to children with SED. One of these providers serves only rural counties. Nineteen providers serve a mix of rural/urban, and four serve only urban counties. Thirty-four (34) percent of all children and adolescents reported served by providers reside in the 63 rural counties of Indiana.

Strengths
We are serving an appropriate number of rural youth. We have increased the number of homeless youth served from the previous years by 73%.

Eighteen rural counties have come together to form a System of Care, using schools as the nucleus to reach SED children and their families.

Criterion 5: Management Systems

Financial Resources
The Division employs blended funding as it administers both state and federal funds to pay for services for children eligible for the Hoosier Assurance Plan. The state contract for both child and adult populations contains state general revenue funds and federal mental health block grant dollars. Even though these dollars are "blended" there remains a detailed accounting of the various sources for auditing purposes.

Role of the Mental Health Block Grant Program in Indiana
The mental health block grant plays an important role in funding services for children and youth with SED. At least ninety-five (95) percent the federal award is passed along to providers as a portion of their state contract. The remainder is designated for administrative costs.

Block grant funds are used to pay for enrollments into the Community Mental Health System. At the time of contracting we are unable to project which providers will need to use block grant funds. Each provider contract states the limitations of block grant expenditures. DMHA funds are used to pay for services such as: individualized treatment planning, case management, outpatient, day treatment, utilization management, and family support. The Division maintains specific accounting procedures for allocation of these dollars.

Allocation of Block Grant Funds
The Block Grant allocation to a provider is dependent on the rate at which that provider uses funds. Provider contracts specify the expenditure of Block Grant funds for treatment, according to the rules contained in PL 102-321. At the end of a fiscal year we

know exactly how much each provider received from DMHA mental health block grant funds. The annual Block Grant Implementation Report includes a table showing the expenditures of funds by each provider. This table has had as few as eight providers and as many as thirty.

Emergency Health Providers

The DMHA Office of Emergency Management and Preparedness has developed short-term interventions with individuals and groups experiencing psychological responses to large-scale disasters. The Office has also developed an All Hazards Emergency State Plan as a mental health standard for the state. They are collaborators with the Indiana State Department of Health, and have secured a $100,000. Grant from the Department and Center for Mental Health Services to provide disaster training. They have trained over 500 mental health and health professionals across the state on Behavior Aspects of Disaster and Terrorism. Portions of this training deal with family and children/youth needs.

Strengths

The process of distributing money to providers assures that those dollars are use to serve children.

The DMHA Office of Emergency Management and Preparedness continues to prepare responders to disasters and terrorism.

Weaknesses

The amount provided for child enrollment is insufficient for even moderate courses of treatment. The lump sum distribution may discourage treatment beyond the intake stages and encourage enrollment of higher functioning youth.

Mental Health Planning Council Issues/Recommendations:

1. **Work toward better integration with public health service delivery.**
   The Children's Committee hopes that mental health screenings can be utilized in a way that assures earlier access to mental health care, while not further taxing the role of the physician. Since primary health care providers see most children, they are a definite access point for mental health screenings and referrals. DMHA should continue to strengthen its collaborative efforts with Indiana State Department of Health, as well as pediatricians, primary care physicians and nurse practitioners.

   Furthermore, it was suggested that we could measure progress by the number of joint trainings and extent of collaborations. An area of concern is that physicians want feedback once they have made a mental health referral and the patient's level of satisfaction with the service.

   - These concerns are difficult to address in the state plan, however, DMHA will attempt to improve its data collection system to include information about

referrals made by health care providers, and once that information is available to share it with stakeholders.
- DMHA has collaborated with Indiana State Department of Health in its application for funding through the State Early Childhood Comprehensive System Planning grant. If awarded, it will help support trainings and evaluation of the child welfare screening.

2. **Need for early assessment and gaps in services for very young children.**
This concern is closely aligned with item 1. Child care providers and Head Start express concern about behavioral issues of very young children and lack of access of appropriate treatment. Part of this is aligned with mental health screenings being available through health care. The other is workforce related, in that there are very few mental health practitioners who work with young children. Suggestions were to expand the use of Consultation Liaison services in the medical area, expand the role of nurse practitioner and link with Indiana State Department of Health in seeking to establish communities as a medically underserved area (to secure more child psychiatrists).

   - The child welfare screening has been in place since January 2005 and is identifying children who need further mental health assessment and treatment. This data and evaluation of its effectiveness are being tracked and is shared with a broad-base of stakeholders.
   - DMHA supports psychiatric consultation liaison work at Riley Hospital for children who are at risk for mental health/emotional problems. Last year over 250 consultations were conducted for children who may not have services available in their communities due to the income restrictions for access to public mental health services.
   - DMHA will provide to the planning council quarterly reports of the number of children, ages 0-3 and 4-7 served in the public mental health system as a means to monitor services.
   - DMHA has linked with the Indiana Infant and Toddler Mental Health Association to train foster parents in the social and emotional development of young children. The IITMHA works to expand training to mental health professionals in early childhood.

3. **Support and expand interface between school and mental health services.**
The Children's Committee is very concerned about the public education drop out rate, and its correlation with unmet mental health interventions. School-based services are a critical way to reach those children as well as those with less critical needs. Several CMHC's are providing school-based services. Systems of Care can be an appropriate intervention for children with school behavioral issues, and strong linkages with schools should be established. At least one System of Care is involved in collaborating with schools that utilize Positive Behavioral Interventions and Supports. PBIS is a research-based *systems* approach designed to effectively educate all students, including those with challenging social behaviors, and to sustain the use of effective instructional practices. School-based screenings can be helpful in identifying

needs. Currently, there are four sites conducting screenings. However, there is some opposition to screenings. The subcommittee urges sites to be scrupulous in securing parental consent for screenings. Additionally, screening should be conducted by professionals, adhering to strict confidentiality standards. It is important that DMHA frame screenings as a way to help parents care for their children rather than to identify children needing services.

4. **Identify ways to serve non-Medicaid children who need mental health services.** During SFY 2005, seventy-six percent of children with serious emotional disturbance served by the public mental health system were Medicaid eligible. Nineteen percent were privately insured and five percent had no health insurance. Over 28,200 were eligible for DMHA funding, but less than half were funded at a fixed rate of $1,607. A 2003 actuarial suggests an average cost of $2,292. DMHA will explore ways to assure that more families access the CHIP program (Children Health Insurance Program) for those earning above Medicaid eligibility levels. However, the committee recognizes that CHIP benefits are limited to 30 sessions and does not cover case management. For children with serious emotional disturbances these are inadequate benefits.

5. **Ensure that children/adolescents with substance use or abuse challenges are receiving appropriate services.**
   The Council has expressed concern about the segregation of mental health and addiction treatment. It has been difficult to track the number of youth actually receiving substance abuse treatment because of the manner in which data is collected and because mental health services are funded at a slightly higher rate, which encourages providers to enroll them as SED rather than needing addiction services.

   - DMHA will continue to link with the resources of the SAPT block grant to bring appropriate integrated trainings to providers and to report to the Council, on a quarterly basis, the number of youth being treated.

6. **Continue and expand collaboration between Juvenile Justice and DMHA**. The committee urges that DMHA use every possible opportunity to educate those systems serving delinquent juveniles about public mental health responsibilities and capacities, while also seeking new ways to provide services.

SECTION III (CHILD AND ADOLESCENT)

PERFORMANCE GOALS AND ACTION PLANS TO IMPROVE THE SERVICE SYSTEM

(Note: All performance indicators for Children's Services are listed as Criterion 3. A cross-reference for Criteria 1, 2, 4, and 5 is noted where appropriate in the text below.)

CRITERION 3 (National Outcome Measures)

Goal A: Maintain the number of children and youth with SED served by DMHA providers.
Target: Maintain current level of services.
Population: Children/adolescents with serious emotional disturbances.
Criterion: Children's Services (Criterion 2: Mental Health System Data Epidemiology).
Brief name: ***Access***
Indicator: The number of unduplicated children with SED that are enrolled in mental health services during the fiscal year by age, gender, race/ethnicity.
Measure: Numerator: Number of children with SED enrolled during the fiscal year.
Denominator: None
Source of information: Community Services Data System (CSDS), the Indiana community services database. Enrollment information is entered into the database by the providers of service.
Special Issues: Enrollment in the database is the method used by the state to fund the providers. Each enrollment triggers a funding payment up to an allocation amount. After the allocation amount is paid, the providers may or may not continue to enter enrollments into the database. Therefore, the providers may be under-reporting actual numbers of person served. Any cuts in funding for the community mental health system are likely to result in fewer persons receiving services.
Significance: Assuring access to service is one of the major responsibilities of the state mental health authority.

Performance Indicator Table

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year Performance Indicator: *Access*	**FY 2003 Actual**	**FY 2004 Actual**	**FY2005 Projected**	**FY 2006 Target**	**FY 2006 Attain**
Number Enrolled	22,339	24,513	26,969	27,000	
0- 3	647	677	698	700	
4 – 12	14,416	15,593	17,107	17,100	
13 - 17	7,276	8,243	9,164	9,200	

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year Performance Indicator Access	**FY 2003 Actual**	**FY 2004 Actual**	**FY2005 Projected**	**FY 2006 Target**	**FY 2006 Attain**
Gender	22,339	24,513	26,969	27,000	
Male	13,601	14,896	16,379	16,470	
Female	8,738	9,617	10,590	10,530	
Race/Ethnicity	22,339	24,513	26,969	27,000	
American Indiana or Alaska Native	68	89	106	106	
Asian	32	66	35	35	
Black or African-American	3,865	4,499	4,983	4,989	
Native Hawaiian or other Pacific Islander	4	8	12	12	
White	16,951	18,121	19,785	19,808	
More than one Race	862	946	1,267	1,268	
Race Not Available	557	784	781	782	
Hispanic	1,229	1,224	1,424	1,550	

Goal B: Children and adolescents with serious emotional disturbance will receive appropriate and comprehensive community-based services.

Target: To maintain current levels of readmission to state psychiatric hospitals at 30 days and 180 days post discharge.

Population: Children diagnosed as seriously emotionally disturbed.

Criterion: Children's Services (Criterion 1: Comprehensive community-based mental health service systems).

Brief Name: ***Reduced Utilization of Psychiatric Inpatient Beds***

Indicator: The number of persons aged 17 and under who are discharged from a state psychiatric hospital during the fiscal year who are re-admitted to a state psychiatric hospital within 30 days and within 180 days.

Measure: Numerator: Number of persons, aged 17 and under, who are readmitted to a State hospital within 30 days and within 180 days.
Denominator: None.

Sources of Information: The state hospitals maintain a database that is separate from the community services database. Information about admission and discharge is contained in that database for each individual served.

Special Issues: The state psychiatric hospitals are medium- to long-term care facilities. Therefore, the number children/adolescents readmitted at 30 days is expected to be quite low. The 180 days readmission also tends to be quite low. Both of these measures are used by the state psychiatric hospital system to monitor quality.

Significance: This measure monitors the effectiveness of community services for children and adolescents who have been discharged from state psychiatric hospitals. As Indiana proceeds to localize (privatize) state psychiatric hospitals, monitoring both 30 day and 180 day readmissions will become an essential quality indicator for both community and hospital services.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year Performance Indicator: ***Reduced Utilization of Psychiatric Inpatient Beds***	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Readmitted at 30 days	n/a	n/a	1	1	---
Readmitted at 180 days	n/a	n/a	4	4	---

Goal C: Evidence Based Practices will be implemented throughout the state within the community mental health system.

Target: To increase the number of evidence-based practices provided by the community mental health system.

Population: Children diagnosed as seriously emotionally disturbed.

Criterion: Children's Services (Criterion 1: Comprehensive community-based mental health service systems).

Brief Name: ***Evidence-Based Practices Provided***

Indicator: The number of evidence-based practices being provided in the state.

Measure: Numerator: For Therapeutic Foster Care indicate (Yes-No) whether it is being provided.
Denominator: None

Sources of Information: Therapeutic Foster Care is available in the State; however, it is primarily provided through the Department of Child Services (child welfare) and is not available to all children or managed by the state mental health authority. Three community mental health providers also report that they provide Therapeutic Foster Care and maintain encounter level data for their service.

Special Issues: Rather than require evidence-based practices by providers, Indiana has chosen to engage in a process to surface effective practices, improve and disseminate them through the resources of the Technical Assistance Center. The TAC provides information, consultation and training to communities and states working to identify, implement and evaluate evidence-based practices. They work with communities on assessing their readiness for change and to build on existing effective practices to promote social, emotional and behavioral health for children and their

families. Through this resource, and approach, communities will be able to measure their fidelity to identified practice modes, undertake outcome management, and receive coaching on the implementation process. As fidelity and outcome data are collected on a wide variety of services delivered throughout Indiana, effective models of care will quickly emerge. These models will be shared and implemented in other communities, according to their communities unique needs.

Significance: None. It is not clear that an evidence-based practice model is actually being implemented or that the practice is consistent across the state.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year Performance Indicator: ***EBP Provided (Y or N)***	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Therapeutic Foster Care Provided	No data	Y	Y	Y	

Goal D: Evidence Based Practices will be implemented throughout the state within the community mental health system.

Target: To increase the number of children receiving Therapeutic Foster Care.

Population: Children diagnosed as seriously emotionally disturbed.

Criterion: Children's Services (Criterion 1: Comprehensive community-based mental health service systems).

Brief Name: ***Evidence-Based Practices Provided (TFC)***

Indicator: The number of children receiving Therapeutic Foster Care through the community mental health system.

Measure: Numerator: Number of children aged 0 – 17 who receive TFC provided by a mental health provider under contract with the SMHA during the year.
Denominator: None

Sources of Information: Three mental health providers under contract with the SMHA offer Therapeutic Foster Care in the State. Data is submitted by the providers to the state database (CSDS) encounter system.

Special Issues: Other TFC is provided throughout the state by the child welfare agency. Of the total number of children served by the mental health system who are living in a therapeutic foster care setting, more than 65% are being served by one of the three mental health providers.

Significance: None. It is not clear that an evidence-based practice model is actually being implemented.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year Performance Indicator: ***EBP Provided (TFC)***	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Number Served by mental health system	No data	467	559	550	
Number Served outside the mental health system	No data	210	271	250	

Goal E: Family caretakers of child and adolescent **c**onsumers will report positively about outcomes.

Targets: To increase the number of family caretakers reporting positively about outcomes.

Population: Children diagnosed as seriously emotionally disturbed.

Criterion: Children's Services (Criterion 1: Comprehensive community-based mental health service systems).

Brief Name: ***Client Perception of Care***

Indicator: The percentage of family caretakers reporting positively about outcomes through the Youth Services Survey for Families.

Measure: Numerator: Number of positive responses reported in the outcome domain on the child and family survey.
Denominator: Total responses reported in the outcome domain on the child and family consumer survey.

Sources of Information: Data is obtained through a telephone survey process using the Youth Services Survey for Families. Responses are entered into a database by the contractor which is submitted to DMHA for analysis.

Special Issues: This information is self-reported by families to interviewers over the phone. Any bias inherent in the methodology and any issues consumers may have regarding responses to the survey are unknown.

Significance: A family's positive perception of the outcomes derived from the treatment services received by their child and themselves is necessary to stay with services until their goals are attained.

Performance Indicator Table

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Performance Indicator: ***Family Perception of Care***	70.1%	69.7%	70%	70%	
Numerator		1,380			
Denominator		1,981			

CRITERION 3 (State Level Measures)

Goal F: To provide case management services for all children and adolescents with serious emotional disturbance who are receiving services through the public mental health system and who are in need of these services.

Target: To increase by one percent the percent of number of children/adolescents with serious emotional disturbance who receive case management.

Population: Children diagnosed as seriously emotionally disturbed.

Criterion: Children's Services (Criterion 1: Comprehensive community-based mental health service systems).

Brief Name: ***Percentage receiving case management***.

Indicator: Percentage of children/adolescents with serious emotional disturbance who receive case management services among those who receive public mental health services.

Measure: Numerator: The number of child/adolescent consumers with a serious emotional disturbance who are receiving case management services during the fiscal year.
Denominator: The number of child/adolescent consumers with a serious emotional disturbance who receive public mental health services during the fiscal year.

Sources of Information: Community Services Data System (CSDS), the Indiana community services database. Encounter information using procedure codes is entered into the database by the providers of service.

Special Issues: None.

Significance: Assuring access to case management services for persons with a serious mental illness is a primary goal of the mental health block grant legislation.

Performance Indicator Table

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Performance Indicator: ***Case Management***	69%	76%	77%	78%	
Numerator	17,260	19,196	21,560	---	---
Denominator	23,013	25,369	28,000	---	---

Goal G: Family caretakers of child and adolescent **c**onsumers will report that they are satisfied with access to services.

Targets: To maintain the number of families reporting satisfaction with access to services each year.

Population: Children diagnosed as seriously emotionally disturbed.

Criterion: Children's Services (Criterion 1: Comprehensive community-based mental health service systems).

Brief Name: ***Satisfaction with Access***

Indicator: The percentage of families reporting positively about satisfaction with access through the Youth Services Survey for Families.

Measure: Numerator: Number of positive responses reported in the access domain on the child and family survey.
Denominator: Total responses reported in the access domain on the child and family consumer survey.

Sources of Information: Data is obtained through a telephone survey process using the Youth Services Survey for Families. Responses are entered into a database by the contractor which is submitted to DMHA for analysis.

Special Issues: This information is self-reported by families to interviewers over the phone. Any bias inherent in the methodology and any issues consumers may have regarding responses to the survey are unknown.

Significance: A family's satisfaction with access to the treatment services received by their child and themselves is necessary to stay with services until their goals are attained.

Performance Indicator Table

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Performance Indicator: ***Overall Satisfaction***	81%	92%	80%	80%	
Numerator		1,380			
Denominator		1,981			

Goal H: Family caretakers of child and adolescent **c**onsumers will report that the services were provided in a manner that was sensitive to the family's culture.

Targets: To maintain the number of families reporting that the services were provided in a manner that was sensitive to the family's culture each year.

Population: Children diagnosed as seriously emotionally disturbed.

Criterion: Children's Services (Criterion 1: Comprehensive community-based mental health service systems).

Brief Name: ***Cultural Sensitivity***

Indicator: The percentage of families reporting positively about satisfaction with the cultural sensitivity of services through the Youth Services Survey for Families.

Measure: Numerator: Number of positive responses reported in the cultural sensitivity domain on the child and family survey.
Denominator: Total responses reported in the cultural sensitivity domain on the child and family consumer survey.

Sources of Information: Data is obtained through a telephone survey process using the Youth Services Survey for Families. Responses are entered into a database by the contractor which is submitted to DMHA for analysis.

Special Issues: This information is self-reported by families to interviewers over the phone. Any bias inherent in the methodology and any issues consumers may have regarding responses to the survey are unknown.

Significance: A family perception that the services and providers are respectful of, understanding of, and accommodating to their culture is necessary to stay with services until their goals are attained.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Performance Indicator: ***Cultural Sensitivity***		92.2%	92%	92%	
Numerator		1,692			
Denominator		1,836			

Goal I: Increase the number of children enrolled in Systems of Care.

Targets: The number of children enrolled in Systems of Care will increase by 5% each year.

Population: Children diagnosed as seriously emotionally disturbed.

Criterion: Children's Services (Criterion 1: Comprehensive community-based mental health service systems).

Brief name: ***Systems of Care***

Indicator: The number of children enrolled in Systems of Care in the community mental health system

Measure: Numerator: Number of children enrolled in Systems of Care
Denominator: None

Sources of Information: Community Services Data System (CSDS), the Indiana community services database. Encounter information using procedure codes is entered into the database by the providers of service.

Special Issues: There continues to be errors in SOC enrollments. Some providers mistakenly enter children as enrolled, while others do not report children who are enrolled. We continue to work directly with providers as they improve their reporting.

Significance: Systems of Care is an effective approach to address the complex needs of SED children and their families.

Performance Indicator Table

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Performance Indicator ***Systems of Care enrollment***	na	723	900	950	
Numerator		723	900		
Denominator					

Goal J: Maintain the number of children and youth with SED served by DMHA providers.

Target: Maintain current level of services.

Population: Children/adolescents with serious emotional disturbances.

Criterion: Children's Services (Criterion 2: Mental Health System Data Epidemiology).

Brief name: ***Penetration Rate***

Indicator: The number of unduplicated persons with SED that are enrolled in mental health services during the fiscal year

Measure: Number and percent of enrolled children/youth compared with the prevalence rate for Indiana SED
Numerator: Number of children with SED enrolled during the fiscal year.
Denominator: The number of Indiana children estimated to live in families with income at or below 200% of poverty level and who are estimated to be in need of services

Source of information: Community Services Data System (CSDS), the Indiana community services database. Enrollment information is entered into the database by the providers of service. Indiana Prevalence Reports based on the 2000 United States Census.

Special Issues: Enrollment in the database is the method used by the state to fund the providers. Each enrollment triggers a funding payment up to an allocation amount. After the allocation amount is paid, the providers may or may not continue to enter enrollments into the database. Therefore, the providers may by under-reporting actual numbers of person served. Any cuts in funding for the community mental health system are likely to result in fewer persons receiving services.

Significance: Assuring access to service is one of the major responsibilities of the state mental health authority.

Performance Indicator Table

(1)	**(2)**	(3)	(4)	(5)	(6)
Fiscal Year	FY 2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 Attain
Performance Indicator: ***Penetration***	72%	80%	78%	75%	
Numerator	23,013	25,369			
Denominator	31,639	31,639			

Goal K: Children and their families will have accessible and affordable housing.
Target: Reduce the number of children who are homeless by 5% each year.
Population: Children with serious emotional disturbances
Criterion: Children's Services (Criterion 4: Targeted Services to Rural and Homeless Population).
Brief name: ***Homeless***
Indicator: Number of homeless SED children/families who are served during the year**.**
Measure: Numerator: Number of homeless youth
Denominator: None
Source(s) of Information: Community Services Data System (CSDS), the Indiana community services database. Encounter information using procedure codes is entered into the database by the providers of service.
Special Issues: It is less likely that children will be enrolled as homeless than adults because if the primary caregiver is homeless the child will be placed in substitute care.
Significance: The number of reported as homeless over the past few years has been growing. It is important to provide services for the most vulnerable population of children.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Performance Indicator ***Homeless***	77	85	150	147	
Numerator	77	85	150	147	
Denominator					

Goal L: Maintain the level of services to children living in rural areas of the state.
Target: To maintain number of children living in rural areas who receive community-based mental health services.

Population: Children with serious emotional disturbances.
Criterion: Children's Services (Criterion 4: Targeted Services to Rural and Homeless Population).
Brief name: ***Rural services***
Indicator: Number of rural SED children/youth receiving services.
Measure: Numerator: Number of rural youth receiving services.
Denominator: None
Source(s) of Information: Community Services Data System (CSDS), the Indiana community services database. Encounter information using procedure codes is entered into the database by the providers.
Special Issues: Over 68 % of Indiana's counties are rural with slightly over 71% of the population aged 0 – 17 living in urban counties. Of the children/ adolescents served by the public mental health system, approximately 70% live in urban counties and 30% live in rural counties.
Significance: Services should be equally accessible whether the child/adolescent resides in a rural area or an urban area.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Performance Indicator ***Rural***	7,454	7,846	8,300	8,500	
Numerator	7,454	7,846	8,300	8,500	
Denominator					

Goal M: Maintain funding from state and federal sources for mental health services for children
Target: To maintain adequate funding to support services for children's mental health
Population: Children with serious emotional disturbances served in the public mental health system
Criterion: Children's Services (Criterion 5: Management Systems).
Brief name: ***DMHA Children's Funding***
Indicator: The amount of DMHA funds expended for children/adolescents with SED
Measure: Numerator: The amount of DMHA funds expended for children with serious emotional disturbances
Denominator: None
Source: Community Services Data System (CSDS), the Indiana community services database. Enrollment information is entered into the database by the providers of service.
Special Issue: Enrollment in the state database is the method used by the state to fund the providers. Each enrollment triggers a funding payment up to an allocation amount. After the allocation amount is paid, the providers may or may not continue to enter enrollments into the database. Therefore, the providers

may be under-reporting actual numbers of persons served. Any cuts in funding for the community mental health system are likely to result in fewer persons receiving services.

Significance: Assuring access to services is one of the major responsibilities of the state mental health authority.

Performance Indicator Data

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2006 % attain
Performance Indicator ***Children's Funding***	$14 M	$14 M	$14 M	$14 M	
Numerator	$14 M	$14 M	$14 M	$14 M	
Denominator					